An evaluation of the quality of private nursing home care: the consumer's perspective

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AN EVALUATION OF THE QUALITY OF PRIVATE NURSING HOME CARE: THE CONSUMER'S PERSPECTIVE

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TO MY MOTHER ANNE McCOMBIE
IN LOVING MEMORY

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ABSTRACT

The views of the regulators and providers have dominated in setting the standards for the private nursing home industry in the U.K. Legislation and guidelines have mainly concentrated on the evaluation of inputs, i.e. the structural characteristics of nursing homes. The more intangible measures of quality in terms of 'outcomes' are less developed and it is only recently that the consumer's view has been considered a possible outcome measure in terms of quality of care.

This study uses qualitative methods to evaluate the quality of care in private nursing homes for elderly people. Over a period of five months during 1988, in-depth interviews were conducted with 46 residents from five private nursing homes registered in one district health authority. Interviews were also conducted with health authority officers responsible for the registration and inspection of nursing homes and proprietors and staff in the selected nursing homes.

The study raises a number of questions about the quality of care as defined in current legislation and guidelines and implemented by the health authorities. It highlights the differences in the concept of quality between consumers, providers and regulators. Whilst consumers attached importance to many of the elements of care that form a part of the existing requirements, they also valued highly other dimensions not considered in the legislation and guidelines which aim to promote the quality of nursing home care.

The implications for policy and practice are considered. A major reorientation in the regulations so that evidence of the continual achievement of quality of care and the quality of life for residents is required. Options that could facilitate the achievement of quality of care include the introduction of outcome standards, education and training of nursing home staff, assessment procedures, consumer participation and consumer advocacy.

PART ONE

THE POLICY ISSUES

CHAPTER 1

THE POLICY CONTEXT

Introduction

The standard of care in the rapidly expanding nursing home industry has gained considerable prominance as a policy issue in recent years. Legislation, direct regulatory mechanisms and guidelines have been introduced with the aim of monitoring standards and promoting quality of care. However, the means of achieving quality of care remain largely defined from the perspective of the provider and regulator, which has tended to focus on procedure, and the more easily measured structural aspects of homes such as spatial dimensions, fire precautions and staff ratios. The application of these standards has become the first measure of `quality' in private nursing homes available to the regulatory authorities and registration of homes is dependent upon them.

Nursing home research in both the U.K. and the U.S.A. has concentrated on the evaluation of `inputs', i.e. lists of desirable characteristics nursing homes should have. Few studies have

ventured into the more intangible measures of quality in terms of `outcome', i.e. the impact of care on the consumer. This is far more difficult to determine, but is nevertheless an important measure of quality of nursing home care. Furthermore, few studies have attempted to determine whether indicators of good quality, such as the application of specific standards, actually reflect good quality of resident life.

It is only recently that the consumer's view has been considered a possible outcome measure in terms of quality of care. More attention is now being paid to the role of the consumer in health care evaluation. The Griffiths Report (1983) emphasised the importance of the consumer in the N.H.S., and the private sector management consultants, Coopers and Lybrand, recommended that patients should be asked what they wanted as a matter of course (Coopers and Lybrand, 1986). Consumer awareness has also been heightened by the efforts of consumer groups such as the College of Health, the National Consumer Council and some of the more active Community Health Councils.

Recently the Griffiths Report (1988) has provided a timely reminder of the importance of the consumer perspective on services, which could complement and balance the professional judgement of regulatory officers.

Objectives of the study

The purpose of this research is to evaluate the quality of care in private nursing homes for elderly people from the perspective of the consumer. The research seeks to gain an in-depth understanding of significant events and processes by focusing on the subjective feelings and perceptions of residents, rather than objective features and characteristics of the homes. A central aspect of the study is the examination of the assumptions of different groups, e.g. residents, providers and regulators.

The main aims of the research are to:

1. Examine the conceptualisation of `quality' of care in legislative regulations, standards and guidance for nursing homes.

2. Identify the dimensions of nursing home life that are important to residents.
3. Identify those dimensions associated with maximum satisfaction for nursing home residents.
4. Identify residents' preferences or aspirations for improvement in nursing home care.
5. Determine the providers' conceptualisation of `quality' of nursing home care.

The major policy questions addressed by the research are the value of national standards as a guide to quality, and the impact of such standards on the quality of care from the consumers point of view. A major consideration is the abilty of the current regulatory system to ensure that nursing home residents receive satisfactory care. A key question is the extent to which quality of nursing home care can be evaluated from measurement of consumers' subjective views and satisfaction and futher, the use of such views in policy-making and planning for the future.

The kinds of questions that the research seeks to address are: the experiences of nursing home

residents; the factors that determine an acceptable form of nursing home living; the factors that contribute to satisfaction with nursing home life; the consistency of residents' views among different types of nursing homes; the significance of current standards and guidance to the quality of life for nursing home residents.

The historical context

Nursing homes are not a new phenomenon. In 1891 there were approximately 9,500 nursing home and convalescent beds in England and Wales. This number increased to 13,000 by 1911, by which time they were virtually all run as profit-making enterprises. Homes cared for a range of cases including maternity, medical, surgical, convalescent, senile and chronic cases. They were also known to provide treatments of a dubious nature such as rest cures and massage. Homes were often run by unqualified nurses and unscrupulous proprietors charging exorbitant fees. Charges across nursing homes varied considerably as did standards of care. The scandals and abuses of patients were not specifically related to the nursing of elderly people, but occured in all

categories of home. An extreme case reported in Truth in 1902, cited by Abel Smith (1964:190), referred to thirteen senile patients accommodated in a two-roomed house:

> "Beds seem only to have been made at intervals of several days; bed linen, however foul its condition to have been changed only at intervals of several weeks... Cruelty of a very real and active kind appears to have been practised, presumably in the way of punishment, upon these feeble and half-witted creatures, while some of them were tied down in bed in a manner which would not be permitted in either workhouse or asylum."

It was the revelation of such abuses that led to demands for the licensing and inspection of private hospitals and nursing homes. The nursing profession were largely instrumental in the orchestration of the campaign for the control of nursing homes, as it was in their interests to protect themselves from the competition of untrained nurses. The British Medical Association were in favour of a system of large private nursing homes with a few beds for patients who would pay less than the full cost, although nothing came of their proposals. In 1904, the committee set up to consider the registration of nurses, recommended compulsory registration and the inspection of nursing homes, however, no

action was taken by the Government. The register of nurses was eventually set up under the 1919 Act, although this did not prevent unregistered nurses working as nurses in private nursing homes.

By 1921, the number of nursing home beds in England and Wales had increased to 26,000 and by all accounts conditions had not improved since the first Bill for registration of nursing homes had been rejected twenty years earlier. In 1925 another Bill was presented, but later withdrawn following considerable opposition from doctors who claimed that it would interfere with professional practice and would also affect those doctors who accommodated patients in their private premises. Finally in 1926 a House of Commons Select Committee was appointed to consider the question of inspection and supervision of nursing homes. The College of Nursing was a strong proponent of registration and it advocated a minimum proportion of registered nurses in every home. The College provided evidence of overcrowding, neglect, abuse and insanitary conditions. The British Medical Association, however, stated that they would only agree to registration if nursing homes run by

doctors were exempt from inspection; if the registering authorities relinquished their power to a committee of doctors and nurses; and if medical records were exempt from inspection by lay bodies. The committee agreed only to the final point and recommended registration and inspection of nursing homes, which were defined as:

> "...any institution that...must habitually cater for patients who, in some degree, are incapable of looking after themselves, and consequently require more or less constant attention, and from the nature of their complaints may be unable to leave the home."
> (House of Commons, 1926)

The committee also recognised a real problem with the `senile and chronic sick' who wished to avoid the Poor Law institution, and recommended the provision of local authority accommodation for this group.

The Nursing Homes Registration Act 1927 gave the local medical officers of health the task of inspection. Under the Act a nursing home was defined as:

> " ... any premises used or intended to be used for the reception of and the providing of nursing for persons suffering from any sickness, injury or infirmity, and includes a maternity home ..."

The emphasis was on the maintenance of basic standards and homes had to be run by a `fit' person in `fit' premises with some qualified person on the staff.

The advent of regulations requiring care to be at least supervised by qualified nurses did not prevent the development of a class of homes for elderly people where nursing care was administered by unqualified nurses. There was no provision for the registration and inspection of these homes until the National Assistance Act 1948. As the central thrust of the Act was with the break up of the Poor Law, public assistance and the creation of a state sector of care for the blind, deaf, disabled and elderly, little consideration was given to private nursing home care of the elderly as it was intended that a state sector would soon be developed to provide for those old persons still able to perform basic activities of daily living, with the exception of household tasks.

Since the National Assistance Act 1948, policy for the public provision of services to the elderly has remained largely unchanged, with the exception

of organisational reform that occured as a result of the Local Authority Social Services Act 1971. The private and voluntary sector of care for the elderly has been largely ignored by policy-makers since 1971.

Registration and inspection of private and voluntary nursing homes became the responsibility of the District Health Authorities (hereafter referred to as D.H.A.s) with the enactment of the Nursing Homes Act in 1975 (later amended by the Health Services Act 1980). By 1978 it became clear that nursing homes had come to cater mainly for elderly people, a group for whom they were not originally designed. There were 31,000 registered beds in private and voluntary nursing homes of which 23,000 were for the elderly and only 460 for maternity cases and about 7,000 for surgical (Challis, 1982).

The topic of local authority residential care was raised in `A Happier Old Age', a consultative paper issued by the Government in 1978 (D.H.S.S., 1978). The quality of life in care, consumer control and staff training were three key issues

raised by the paper in respect to residential care. Although the provision of private residential and nursing home care was not mentioned, the question of National Health Service (N.H.S.) nursing home provision for old people in need of continuing care was raised. Nursing home care was however, never developed within the National Health Service with the exception of three pilot projects set up in the early 1980s. N.H.S. long-term care mainly remains under the medical speciality of geriatrics, still in some cases provided in the nineteenth century institutions of the Victorian Poor Law. More recently however, in some D.H.A.s, e.g. City and Hackney, one or two N.H.S. nursing homes have opened.

The control of public expenditure being exercised by the Conservative Government did not bode well for any further development of local authority or N.H.S. care of the elderly. It was in this political climate that the contribution of private nursing homes to the care of the elderly was enthusiastically recognised in 1981 by the Conservative Government in its statement on policy

for health and social services (D.H.S.S., 1981a). There were no signs that the concept of community care as the major policy response to the increasing problem of dependency in the elderly, would solve the need for long-term beds (Bartlett, 1987). Support services to keep elderly people in their own homes have not developed sufficiently in real terms, consequently the demand for long-stay care remains, and the private sector has been able to fill an ever-increasing need as the numbers of older elderly people increase.

In 1981 the White Paper, `Growing Older', encouraged Health Authorities to make contractual arrangements with private nursing homes (D.H.S.S., 1981b); it also proposed some reforms in the registration and inspection of private homes.

The regulation of private nursing homes remained a separate system from the regulation of private residential homes; the registration and inspection of the latter was the responsibility of the social services department, under the control of the Residential Homes Act 1980. In 1982, a consultative paper, `A Good Home' was issued

(D.H.S.S, 1982). This formed the basis for reforms that followed in 1983 with the enactment of the Health and Social Services and Social Security Adjudications Act 1983.

A significant new provision under this Act was for dual registration, an arrangement whereby a nursing home may also be registered as a residential care home. If nursing homes provide personal care rather than nursing care for four or more residents, then they must be dually registered with the D.H.A. as a nursing home and with the local authority social services department as a residential care home. This provides for continuity of care should someones condition change, thus allowing for the widest range of care provision within one home.

Registered home tribunals were also established under the provisions of the Health and Social Services and Social Security Adjudications Act in 1983. The tribunal allows proprietors to appeal if a nursing home is refused registration or is deregistered by the D.H.A. The tribunal consists of a legally qualified person in the chair and two

experts for nursing homes; a medical practitioner and a qualified nurse.

Current regulation

The fragmented system of regulation for nursing and residential homes was consolidated in 1984 under the Registered Homes Act 1984. Part II of the Act deals with nursing homes and mental nursing homes. Essentially the Act was designed to strengthen regulations governing the nursing and residential home sector and to improve standards. Nursing home regulation consists of three main components: standards governing all aspects of a home's operation; standardised procedures and criteria for monitoring the performance of homes and for determining the extent to which they comply with the criteria; and the enforcement of compliance in cases where unsatisfactory performance/ standards are found.

All nursing homes are required under the 1984 Act to be registered and under the charge of a registered medical practitioner or qualified nurse. The Act further requires the person-in-charge to be a `fit' person and provides for the

refusal or withdrawal of registration should any section of the Act not be adhered to, or if the condition of the home is unsatisfactory or unsuitable. Homes are to be regularly inspected and the Secretary of State has the power to make regulations about the provision of facilities, staff cover, record-keeping, inspections, fees for registration, and other related matters.

The 1984 Act was part of a package which also included the Nursing Home Regulations (SI 1984/1578), Health Circular (HC 84/21) and the Registered Homes Tribunal Rules 1984 (SI 1984/1346). (A more complete list of the main Acts and Regulations applicable to nursing homes is shown in Appendix 1).

The advice and model guidelines, published in the form of a handbook by the National Association of Health Authorities (N.A.H.A.), interprets the 1984 Act and regulations and forms the basis of guidance which D.H.A.s give to prospective nursing home proprietors (N.A.H.A., 1985). The guidelines describe the circumstances in which nursing care may be given as:

1. when a person's health deteriorates to such an extent that he/she needs constant nursing care;
2. where a person's health is such that one or more of the following procedures is required periodically over 24 hours:
- administration of medicine by injection,
- dressings to an open or closed wound,
- artificial feeding requiring nursing skills,
- basic nursing care of the type given to bedfast people,
- frequent attention because of single or double incontinence.

The guidelines differentiate nursing home care from residential home care by describing a residential care home as an institution providing the kind of care "broadly equivalent to what might be provided by a competent and caring relative, able to respond the emotional as well as physical needs". The kind of help referred to includes washing, bathing, dressing, toileting, administration of medicine and calling a doctor when necessary.

The 86 pages of guidelines cover conditions relevant to all kinds of nursing homes, with a special section on the needs of elderly people. The guidelines focus more on the physical and material aspects of nursing home life than on quality of life issues. The fourteen main areas include registration and inspection, staffing, accommodation and general services, furniture and equipment, food service and facilities, linen and laundry, the disposal of waste and infected materials, control of infection and of drugs, fire safety, accident prevention, records, notifications of deaths and complaints.

Quality of life is touched on in the recommendations concerning the availability of leisure activities, flexible visiting arrangements, rising and bedtimes. This advice appears only perfunctory in comparison with that contained in the Code of Practice for residential care homes, where the emphasis is less on the physical and material aspects of life and more on quality of life (Centre for Policy on Ageing, 1984).

In 1987 the N.A.H.A. sought the views of health authorities on the N.A.H.A. guidelines. Topics on which further guidance was frequently requested were quality of life, staffing, advice on procedures, and pharmaceutical services. As a result, a supplement to the 1985 guidelines was produced containing guidance on those matters identified by health authorities (N.A.H.A., 1988). However, the nature of this additional guidance is described as having "no specific statutory forces as such", but "comprises recommendations which are implicit in that statutory basis".

The section entitled "Quality of life for the elderly, long-stay patient" addresses some of the major concerns about residential living currently being debated more widely, and demonstrates a significant shift in thinking, (if not yet in practice), about the assessment of nursing home care. Of course there is no guarantee that the supplementary guidelines will be taken on board by health authorities. A study conducted early in 1989 revealed that only 22 per cent (41) of D.H.A.s had amended their guidelines or procedures as a result of the supplement, but only just over

half of these (22) had made amendments to their quality of life guidelines. A decision not to change their current guidelines had already been made by 35 per cent of the D.H.A.s. Others were still considering the document or deciding the amendments to be made (Happold, 1989).

In relation to the section on quality of life, the supplement lists thirteen criteria by which homes can assist patients retain their personal dignity and maximum independence. These include the provision of sensitive care that takes account of social, emotional, religious, cultural and ethnic needs; respecting personal privacy and allowing control over financial and personal affairs; consultation about routines and participation in discussion about changes; choice of doctor and informed choice about future health care and personal plans; access to community and social facilities and access to an `advocate'; freedom from restrictions and the opportunity to exercise civic rights and duties.

A further section is provided by the supplement designed to assist the assessment of `qualitative'

aspects by inspecting officers. This consists of a series of questions relating to the patients' lifestyle and concerned with "ascertaining and meeting the wishes and needs of the patients". The questions are grouped under the broad headings of dignity, spiritual needs, social aspects of physical needs, e.g. food and sleep, and recreational and diversional activities.

Social Security legislation

Policies governing the public funding available to support elderly people in private nursing and residential homes have had a major impact on the industry and have raised questions about value for money, standards and the growth of the industry. Although the collection of information on nursing homes did not separately identify the places available for elderly people before 1982, since then the statistics reveal a clear upward trend in the provision of private nursing home beds for the elderly. In England alone, private and voluntary nursing home places for elderly people increased from 20,962 in 1982 to 28,416 in 1984 (Larder et al, 1986:17). These places are distributed

unevenly across the country; in 1984, 67 per cent of nursing home places were situated in the South of England.

It has been widely asserted that the availability of public funds since 1980 to pay for nursing home care, in the form of Supplementary Benefit board and lodging allowances, has been a major factor contributing to the dramatic growth in the nursing home industry. Statistics provided by the Audit Commission show that the number of people in nursing and residential care homes receiving this benefit has risen from 12,000 in 1979 to 90,000 in 1986. Over the same period, the proportion of patients and residents in receipt of this benefit had increased from 14 per cent to 54 per cent (Audit Commission, 1986).

Government concern at the escalating costs resulted in a number of successive policy changes in 1983, 1984 and 1985, that attempted to standardise the system of board and lodging payments for claimants in nursing homes (Bartlett, 1987). Such changes did not however, provide a satisfactory solution to the problem of rising

expenditure. Finally a joint central and local working party was set up to address the issue, and particularly to consider the relationship between charges, standards of provision and value for money. One of the outcomes of this working party was the publication of the Firth Report (D.H.S.S., 1987), which recommended that local authorities should be given responsibility for financing all residential care costs in the public and independent sector where residents were unable to meet the full cost themselves. This, the report considered, would not only improve the control of public expenditure, but would also make local authorities responsible for the professional assessment of need and the setting of standards for residential care homes. The fate of nursing homes was not considered in this report, but later, the Griffiths Report (1988), which reviewed policy for community care, recommended that nursing homes be included in any arrangement for providing public support for residential care. Griffiths believed, however, that the social security system should provide the financial assessment of claimants, and that the local authorities should assess all care needs.

The enforcement of regulation

It is now five years since the Registered Homes Act 1984 was enacted and difficulties are still being experienced with the enforcement of standards in the nursing home industry. During the course of this and previous research, there were many examples of homes that had clearly never conformed to the regulatory requirements but whose registrations were not revoked. Scandals in the industry still cause public concern and staff engaged in the registration and inspection of nursing homes still complain about their lack of power. In the words of one officer interviewed during the course of this study:

> "In essence, the problem is that the D.H.A. is held responsible for regulation, but has neither the legal powers or resources to enforce standards."

A number of authors (Sabatier, 1985; Barrett and Fudge, 1981) argue that policy studies of a programme's effects should take a long-term perspective. Ten to fifteen years is considered appropriate and shorter time intervals are likely to produce erroneous conclusions and overlook the processes of policy evolution and learning.

Changes in socio-economic conditions, interest group support, elections, and learning by both proponents and opponents are all likely to affect the direction of programme change. In the case of the nursing home industry, however, five years does not seem an unreasonable interval at which to analyse the progress of new directives enshrined in the Registered Homes Act 1984.

Given that the criteria by which nursing homes are currently assessed are the more easily measurable aspects of care, then questions must be raised about the nature of a regulatory system that fails to provide the means to ensure more consistency in standards across the country.

Theory of regulation

It is helpful to turn to the theory of regulation in order to analyse the system by which standards are enforced in the nursing home industry. Banting (1971) describes regulation as a mechanism whereby the state sets rules, backed by sanctions, prescribing certain behaviour within the economy or society. They may be designed to adjust social

or economic patterns, and are essentially formulated to protect the interests of individuals, special groups, industries or the state itself.

Two basic enforcement options are available to regulatory authorities and are commonly referred to in the literature as the compliance and deterrence strategies (Hawkins and Thomas, 1984). Regulatory strategies that fit the compliance model demonstrate a supportive relationship between the regulator and regulated, and emphasize the prevention of problems. The provider is motivated to improve standards through constructive advice, negotiation, publicity and persuasion. Another `soft' option is the setting aside or modification of rules (Hood, 1986). This could involve bargaining on a case-by-case basis and compromising on alternative arrangements which uphold the spirit of the rules. The deterrence model however, can be categorised as a `hard' strategy. Punishment and recourse to legal proceedings are the hallmarks of this approach. An additional `hard' strategy would be to make it

physically difficult or inconvenient to break the rules.

The disadvantages of relying exclusively on any one method have been well documented (Hood, 1986). For example, reliance on soft methods would ultimately make all rules negotiable and voluntary. Harder strategies of enforcement, however, make it impossible to set aside or modify rules in conditions where they are inappropriate or conflicting and may generate unnecessary conflict. Vladeck notes that regulation tends to penalize the very best or more efficient institutions while focusing on the worst (Vladeck, 1981).

Alternatives facing the regulator therefore, would be to combine strategies, or to select a strategy to fit the type of violation. Hard enforcement strategies may not change incompetent behaviour and a more appropriate strategy to change behaviour may be a softer approach which counsels and informs. Equally, harder enforcement strategies may be the only solution where rules

are evaded because the chances of detection and punishment are minimal.

Regulation in Britain tends to be low-key and conform to the `soft' compliance model where standards are flexible, informal, and there is often a voluntary element, or even self-regulation (Day and Klein, 1987). This situation has been attributed to weak and sporadic legislative oversight, limited resources and the underdeveloped system of administrative law capable of providing a check on administrative discretion (Elkin, 1986). Given the small number of Ministers actually involved in generating a particular piece of legislation, compared with those appointed to carry out the policy, it is feasible that Ministers can only be concerned with seeing that broad policy directions are maintained.

This approach indeed holds true in the case of the regulation of the nursing home industry. The regulatory responsibilities for nursing homes are delegated by the Department of Health and Social Security (D.H.S.S.) to the 192 D.H.A.s which are

responsible for registration and inspection of nursing homes. There are no systematic mechanisms by which the D.H.S.S. can even find out if there is consistency in the application of standards across the country.

Legislation governing the nursing home industry is complemented by a voluntary agreement in the form of a code of practice which sets out a number of principles of conduct (N.A.H.A., 1985) upon which D.H.A.s can base their requirements. This code of practice is non-statutory in that it cannot be enforced in the courts. It could however be considered to have a quasi-legal status, in that any infringement can be considered by the nursing homes tribunal and used to establish negligence or liability in a particular case.

Despite the seemingly 'weak' status of the N.A.H.A. guidelines, such a voluntary instrument of regulation does have its advantages (Baggott, 1986). It can go much further than the legal regulations by covering detailed practices which could not be described easily in legal terminology. It also has flexibility because the

normal process of parliamentary approval can be avoided and alterations, therefore, made at fairly short notice. New developments can be quickly and easily incorporated as the need arises, for example the supplement to the N.A.H.A. guidelines included major new guidance on quality of care (N.A.H.A., 1988).

A further feature of the nursing home regulatory system, that influences the way in which standards are enforced, is the choice of the enforcement agency. As it has already been noted, the responsibility for inspection falls to the D.H.A.s; enforcement is therefore in the hands of public bureaucracies. Lipsky's analysis highlights some of the strategies adopted by street-level bureaucrats to circumvent the intentions of policy-makers (Lipsky, 1980). There are two particular problems in relation to nursing homes concerning the nature of such control. First, there are no standards of practice relating specifically to the public sector, apart from the Health Advisory Service created in the 1970s to inspect services and institutions across the public sector. Despite this, poor practice and low

standards of care in institutions provided by local authorities continues to be identified (Clough, 1981; Willcocks et al, 1987).

Secondly, it is believed that where rules are mainly or exclusively enforced by public bureaucracies, the result will be under-enforcement (Becker and Stigler, 1974). This is because the gain to the enforcement agency under such a system, is often less than the offender's potential penalty. Here, the political environment could be of major importance in the decisions taken by public bureaucracies; a key factor affecting a decision to apply the ultimate sanction and close down a nursing home could be the availability of alternative forms of care for any displaced elderly residents. The previous discussion has already referred to the inadequate level of N.H.S. long-term care for the elderly and the heavy demand for private nursing home beds that would make the closure of a nursing home an unattractive option.

The choice of particular enforcement staff also has a bearing on how regulation will be conducted.

In the case of nursing home regulation, many of the inspectors appointed by the D.H.A.s are nurses. Their professional standing makes it more likely that the style of regulation will comply with that of the compliance model; they will use professional discretion and judgement, and depending on their interpretation of what they find, different strategies of enforcement will be applied. Day and Klein observe:

> " .. the reality of regulation is of a group of surveyors arriving in an untidy situation where they rely on their personal and professional sensors to pick up cues and hints which may signal deeper discontents."
> (Day and Klein, 1987)

It could also be argued that because the professional training and background of the regulators is similar to those working in the industry being regulated, there may be a tendency to protect the industry's interests rather than those of the anonymous consumer (Vladeck, 1981). Davis points out that many of the difficulties facing law enforcement officials in the nursing home industry are created because they do not have powers of enforcement in the normal course of their jobs (Davis, 1987).

In many respects, the position of regulators can be regarded as one that commands considerable power and autonomy. In their comparative study of regulation of nuring homes in Britain and the U.S.A., Day and Klein (1987) observe that in practice professional cultures overcame the differing political cultures that had shaped regulatory models. In other words, despite the apparent difference in regulatory styles between New York, Virginia and England, in the day-to-day practice of inspection, the nurse inspectors employed similar techniques.

Sabatier argues however, that it is possible that the emphasis of early studies of implementation on explaining programme failures has led to the autonomy of street-level implementors vis-a-vis formal policy makers being overestimated. Unclear goals and directives were more likely to have explained the local discretion and variation in programme performance (Sabatier, 1986).

In terms of determining the success or otherwise of the regulatory strategies currently in place for the nursing home industry, there are a number

of key factors to look for. In relation to the initial policy decision (e.g. a statute) there are three important factors. First, the statement of objectives should be clear and consistent. If objectives are too complex, it is unlikely that the regulatory system will achieve any of them, particularly if they are contradictory. If the rules being enforced are ambiguous or imprecise, this inevitably leads to the use of discretion in regulation, where judgements may depend on the interpretation by regulators of the behaviour of the regulated. This situation is seen in the regulation of nursing homes in relation to the standards imposed by local D.H.A.s across the country. Whilst the model guidelines produced by N.A.H.A. (1985) form a basis for many of the standards developed by D.H.A.s, they are modified to varying degrees, thus presenting an inconsistent picture of the requirements across the country. In some Districts for example, stair lifts are banned from nursing homes, whilst other authorities still allow their installation if necessary.

At an even more individual level, officials can also operate varying degrees of discretion in their interpretation of the local guidelines. For some, the relationship with nursing home proprietors takes on that of a policing role, whereas others act in more of an advisory capacity. This situation was highlighted in a study of the public regulation of private nursing homes:

> "One D.H.A. tended to emphasise the law and compliance with all the details of the guidelines....Another D.H.A. officer took a detached view of legal responsibilities and operated minimum controls, interpreting differently the duties involved."
>
> (Davis, 1987)

The case of dual registration is a further example in the legislation governing nursing homes where unclear objectives have led to problems with the enforcement of regulation. Whilst in theory the concept of dual registration seems a logical solution to unnecessary fragmentation of care, in practice there have been major problems in its implementation. The root of this problem is the conflicting guidelines for each type of home with respect to, for example, staffing levels, qualifications of staff, room sizes, communal

areas, social aspects of the home's regime and record keeping. This obviously complicates the process of conducting joint inspections. Further, precise definitions of nursing and personal care continue to be ellusive.

Weiner argues that objectives are clearer if there are review criteria, i.e. key factors that are to be the subject of regulatory attention should be identified. Attempts to address too many factors may undermine the efficiency of the regulatory process and may also intrude unnecessarily into the management of the institutions themselves. Weiner warns:

> "The regulatory process should be concerned with a greater level of detail only if any of the techniques used adversely affect important public values, for example, if the decision to close an institution leaves the affected population without access to adequate alternative services." (Weiner, 1981)

Davis also concludes that a potential danger of too many regulations is to increase the chance of already vulnerable, dependent residents becoming victims (Davis, 1987).

A second factor is the existence of an adequate causal theory. As various authors have

demonstrated, policy-makers can strongly affect the implementation process by basing a program on a valid causal theory rather than a dubious one (Pressman and Wildavsky, 1983).

Thirdly, the legal structure of the regulatory process is also considered to be an important variable. It is argued that such a structure is crucial to enhance compliance by implementing officials and target groups (Sabatier, 1986). The introduction of the Registered Homes Tribunal by the 1984 Act, may have the effect of introducing a more legalistic content into the regulation of homes by setting precedents for authorities and homes to follow.

Weiner (1981) advises, however, that the process should function with relatively limited procedural constraints to enable flexibility in responding to new or changed circumstances. Elaborate procedures could serve to frustrate the objectives of regulation. The broader the scope of the regulation, therefore, the more likely it is to be effective.

Other variables, that are largely the product of subsequent political and economic pressure during the implementation process, are listed by Sabatier as necessary conditions for the effective implementation of legal objectives. These include having committed and skillful implementing officials, support of interest groups and sovereigns and changes in socio-economic conditions which do not substantially undermine political support or causal theory (Sabatier, 1986).

Sabatier suggests that such mechanisms, in addition to the financial resources available, are available to official policy-makers to guide the behaviour of street-level bureaucrats and target groups (Sabatier, 1985).

The picture is however, further complicated in the case of nursing homes because the regulators are more concerned with organisational behaviour over time as opposed to individual acts. It is therefore more useful, suggest Day and Klein (1987), to analyse regulation in terms of ongoing social relations between regulators and regulated.

An important feature of the regulatory system is that it depends to a certain extent on self-regulation and this necessarily involves the development of trust relations with nursing homes.

The technological model, on the other hand, assumes that quality of care can be defined, measured, and also guaranteed given competent management. A major problem with such an approach argue Day and Klein, is that outcome measurements will not necessarily reflect quality of care, and further, outcome measures in the nursing home context are more likely to be continuing processes such as the maintenance of dignity, privacy and self-fulfilment, rather than morbidity or mortality.

The question remaining for this analysis is the extent to which the regulatory process can encompass both process and outcome measures of quality. If outcome measures that address the consumer's view of quality are to be taken seriously, what kind of instruments will need to be adopted for such standards to be enforced effectively?

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CHAPTER 2

THE MEANING AND MEASUREMENT OF QUALITY OF CARE

In chapter one, it was argued that the guidelines developed to regulate the nursing home industry and improve standards, make only a limited attempt to consider the broader aspects of quality of care, the focus remaining on more easily measured structural aspects of nursing home care. Of course, it is true that inputs are important, particularly where the safety of residents is concerned, and that in the past many homes have been very deficient in these areas. In this respect, the implementation of new regulations is having a considerable impact on the industry and is welcomed by the majority of proprietors keen to improve the image of nursing homes. It would appear however, that regulations and guidelines for the industry have only gone part of the way in their attempt to improve conditions in nursing homes. Despite increased inspections and the introduction of an appeals tribunal, which gives D.H.A.s more power to enforce standards, media reports that reflect unfavourably on the quality of care in nursing homes are still common.

The traditional approach to quality assessment has been to focus on `inputs' because of their ease of measurement, and this is the case in the nursing home industry. The reasons for this more technical emphasis in nursing home guidance when compared with the psycho-social approach taken in guidance for residential care homes (Centre for Policy on Ageing, 1984), can be partly attributed to the historical factors outlined previously, that have shaped legislation affecting how each care environment has developed.

Nursing homes have always been viewed as an extension of the hospital system and operating with the same values. Consequently nursing home residents have been treated in a similar way to hospital patients. This is unsurprising and is supported by recent research that has shown how few qualified nursing staff in the nursing home sector have any form of special education or training in long-term care of the elderly (Challis and Bartlett, 1987). Because of this, contemporary nursing techniques (the nursing process) that apply an holistic approach to patient care and

enable patients to participate in their care plan, are rarely seen in nursing homes. The traditional nursing approach predominates and is reflected in guidance for the industry. Considering that the average length of stay in a nursing home is two years, it is crucial that further attempts are made to address the question of quality so as to promote real improvement in the way care is given.

The concept of quality is not simple, it has many definitions and measures and has numerous components which vary with the perspective taken. This chapter analyses the meaning of quality, identifies the various approaches by which quality of care has been measured in different health care settings, and considers the relevance of current debates on quality to the nursing home industry.

The emergence of quality as a policy issue

The rapid growth of health care expenditures in the U.K. has been an important factor in the identification of quality as a major issue on the health policy agenda during the 1980s. Interest in quality has been a visible public issue in the

U.S.A. since the late 1960s. Public and private patients are increasingly demanding value for money as expenditures through private health insurance and Medicare and Medicaid programmes increase. The renewed interest in quality in the U.S.A. in the 1980s is associated with the effect of cost containment efforts, in particular the prospective payment system based on diagnostic related groups, on quality of care. The emphasis is now on monitoring and preserving quality to the satisfaction of various interested parties including the Congress, the press and the general public (Wyszewianski, 1988).

In the U.K. the issue of quality has arisen more in the context of the relationship between the Government and the medical profession, although challenges to medical sovereignty have been somewhat restrained. The key parties in todays debate about quality are the D.H.S.S., the medical institutions, research and training institutions (e.g. the Kings Fund), individual health authorities and consumer groups (Pollitt, 1988). Whilst everyone is in favour of quality, Pollitt points out that the concept is "in danger of

meaning all things to all men (and women) and ... open to sutle abuse".

Defining quality

Quality of care is a difficult concept to define and consequently its assessment has not always proved satisfactory. Numerous attempts have been made at assessing quality of care in a variety of health care settings and using a range of approaches. A reminder is provided by Wyszewianski's analysis that considerations of quality of care assessment began in 1914 and that the literature on quality of care now comprises many hundreds of studies (Wyszewianski, 1988). Inevitably, definitions and approaches to quality of care have varied in their perspectives, but they nevertheless provide a valuable background to current concerns and debates.

Donabedian wrote extensively on the evaluation of quality of medical care. Commenting on the difficulties of defining quality he states:

> "The definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part."
> (Donabedian, 1966)

The highest quality of care was viewed by Donabedian as:

> "that which yields the greatest expected improvement in health status, health being defined broadly to include physical, physiological, and psychological dimensions."
> (Donabedian, 1982).

He considered that such a view of quality has two components: a definition and measurement of health status and of changes or differences in health status, and a specification of the medical care associated with any given health status outcome.

More recent debates about quality at the King's Fund have defined quality as:

> "... a combination of criteria of service including effectiveness, acceptability (to consumers and providers), equity (of access and distribution) and economy." (Shaw, 1986)

Kane and Kane (1988) conclude that definitions of quality must include the elements of care that are meaningful to the consumers. This should therefore take into account not only the care but also the environment in which it occurs, including the more

intangible outcomes such as adequate quality of life. Implicit in this approach to the definition of quality, it is suggested that standards of acceptable performance must be required and this will involve "value-laden decisions" about "how much quality our society wishes to purchase for the elderly".

Evaluation of quality

Donabedian distinguishes three major approaches to the evaluation of quality in the literature: assessment of structure, process of care, and outcome. This is a useful organising scheme to examine quality in nursing home settings.

First, assessment of structure has focused on the settings in which care takes place and includes such characteristics as staffing levels and qualifications, facilities, financing, administration, etc. This approach assumes that good quality will follow if the setting is satisfactory.

Assessments of the quality of nursing home care have been dominated by structural criteria. For example, Greene and Monahan (1981) argue that direct patient care resources and activities are good indicators of the quality of care actually being provided. In their study of nursing homes, the quality of care measure used is an unweighted composite index of nursing hours, nursing expenditure, patient dietary expenditure and miscellaneous direct patient care expenditures. They conclude from their findings that profit-making facilities provided lower levels of care than non profit facilities and that distantly headquartered chain operations provided lower care levels than locally owned facilities.

Other attempts at evaluating quality in nursing homes using a structural approach include the construction of a rating scale (Linn, 1966). This involves a two-part scale; the first records such characteristics as size, patient turnover rate and staffing levels. The second includes items considered necessary or desirable by accreditation programmes. The scale was primarily intended for correlation with patient outcome.

The second approach, the process of care, is concerned with the `delivery' of care and embodies "both the technical competence of the provider and the interpersonal or humanistic aspects of the patient-provider relationship" (Lohr, 1988). From the technical perspective, judgements are based on such factors as the standards and competence of clinical history taking, physical examination and diagnostic tests, continuity of care and therapeutic procedures. The approach necessitates the specification of relevant standards against which to base an assessment, and is more concerned with professional practice than its impact. There is an assumption underlying this approach that competent performance produces care that is beneficial to the patient. Peer review and medical audit are the commonly used measures. Review of medical records by physicians may be conducted from which an opinion as to the quality of care may be arrived at. The medical audit approach involves the development of criteria by panels of experts in the field against which to judge quality.

The focus of the technical dimension inevitably excludes consumers from participation in quality of care assessment because they are assumed to be technically incompetent, even to the extent of identifying areas that are of concern to them. However, in the humanistic element of the care process, the importance of integrity and compassion on the part of the care giver is emphasized. It is therefore possible to define, observe and measure both aspects of the process of care. Historically however, most quality assessment work has stressed process-of-care evaluations and levels of the technical, rather than the interpersonal, quality of care.

The emphasis has now turned to patient outcomes, the third major approach identified by Donabedian. Studies using the outcome approach to assessing quality of care demonstrate how difficult it is to specify appropriate outcomes of care. Some have focused on mortality and morbidity, others concentrate on physical and social functioning. The range of potential outcomes includes the classic list of the five Ds: death, disease, disability, discomfort and dissatisfaction. Lohr

points out, however, that todays preferred concepts look at the more positive aspects of health - survival rates, states of physiologic, physical, and emotional health, and satisfaction (Lohr, 1988). The assumption is made that given similar cases better care should result in a shorter illness period, reduced death rate, reduced pain and changes in other personal health aspects of the patient.

Death can be used as an indicator that quality of care may have been compromised, particularly when it is untimely, unexpected or avoidable. In the U.S.A., this concept underpins the release of Medicare mortality rate data by the Health Care Financing Administration. When demographic and case-mix variables are taken into account, hospitals with significantly higher overall or diagnosis-specific death rates are targeted for an in-depth review of care by Peer Review Organisations. Although there are drawbacks to the use of mortality rates as an outcome measure, they are a potentially useful nonintrusive method of providing evidence of outliers as indicators of substandard care. In relation to residential care,

Booth (1985) used mortality rates to measure the impact of types of regime, taking into account the age, length of stay, sex and dependency of residents.

Other measures of outcomes - disease, disability and discomfort - can be obtained more directly from patient or medical records. Physiologic tests and procedures may be used to evaluate the quality of care for chronic illness, in addition to the continuation of physical symptoms. Disability measures are commonly based on time spent in a state of ill-health and can be used to track the progess of programmes or a health care delivery system as a whole. Numerous measures of health status exist that relate to disease, disability, psycho-social functioning, quality of life and general health.

A number of authors have emphasized the importance of the conceptualisation and measurement of quality of life for health policy and evaluation research (Kaplan and Bush, 1981). The instruments to measure the quality of life may be single or multiple and employ a number of differing

approaches. They may be qualitative or quantitative, objective or subjective, global or domain-specific. Definitions of the quality of life appear to be as numerous and varied as those applied to the quality of care. Terms used in connection with quality of life include self-esteem (Ziller, 1974), well-being (Carstensen and Cone, 1983), value of life (Bayles, 1980), happiness (Shinn and Johnson, 1978), and life satisfaction (Ferrans and Powers, 1985), to name but a few. The majority of studies reporting on quality of life adopt a multidimensional approach to the concept that often incorporates physical, social and emotional dimensions.

In respect of residential living for elderly people, a range of subjective indicators have been used to measure psychological well-being and scale inner states such as morale, life satisfaction, adjustment, happiness and self-esteem. Many of these instruments are specifically designed for use with elderly people. For example, a modified version of the Adjustment to Ageing Scale developed by Abrams (1978) was used by Willcocks et al (1987) in their National Consumer Study of

local authority residential homes. This attempted to measure how well or badly older people feel they have come to terms with growing old.

Donabedian (1982) suggests that the study of patient satisfaction can be considered an outcome in its own right. Many of the instruments developed to measure patient satisfaction include questions about access to health care, availability and financing, in addition to quality of care. Ware et al, for example, asked their subjects to indicate their level of agreement with a variety of statements about the technical quality and interpersonal aspects of care (Ware et al, 1983). In this study, the aggregate reaction to the process of care forms the outcome and to that extent can be regarded as valid measures of one aspect of the care received.

A particularly innovative attempt at quality measurement is the concept of the quality-adjusted-life-year (Q.A.L.Y.) which combines outcome measurement with a consumer valuation of output. Two scales are used to classify the patient's quality of life according to their

distress/discomfort and functional disability. Using this approach, quality is defined as:

> "the worth of the expected change in the distress and disability status of the patient as a result of a specified medical intervention, where worth is valued by a structured sample largely composed of patients and potential patients." (Pollitt, 1988)

De Geyndt (1970) proposes five approaches for assessing the quality of care. In addition to process, structure and outcome, he proposes the assessment of content and of impact. The content approach is concerned with the practice of medicine in terms of the adequate and appropriate use of laboratory or x-ray procedures, or for example, the use of appropriate drug of blood type. The process view proposed by De Geyndt differs slightly in its emphasis; being more involved with looking at the total management of the patient, it incorporates prevention, therapeutic intervention, and physical rehabilitation. Coordination of total services to the patient is important along with the enabling role of administration.

Impact concentrates on the effect of care on the overall community setting. This approach

therefore includes individuals who have not seen physicians in the overall quality judgment, thus providing more generalizable results. In a wider population not receiving care, detection of poor outcomes in respect to access, outreach and medical practices, may be indicators of poor quality of care.

There have been attempts to evaluate quality that combine all or many of the approaches discussed. A quality assurance project in Wisconsin devised a `multiattribute utility model' as the basis for determining a nursing home's ability to deliver good care (Gustafson et al, 1980). A panel comprising professionals, regulators, academics and consumers, devised lists of quality components summarised to form a composite model. Eleven major criteria were identified representing a combination of process, structural and outcome measures, each with weighted components:

- Philosophy
- Safety of facility
- Management
- Staff
- Care management

- Ties to community
- Resident/staff relations
- Resident population
- Residents' condition
- Professional ties
- Activities

An Australian study of quality, staffing and dependency in non-Government nursing homes developed a general quality measure for nursing homes that assessed five aspects of the nursing home (Department of Community Services, 1986):

1. General care including care planning, meals, hygiene, medication.
2. Access to therapies and recreational activities.
3. Flexibility of policies, privacy, security, staff education and facilities.
4. Buildings, environment, layout, furnishings.
5. `Homeliness' based on the opinions of the research assistants.

In addition, for each of the units studied, further data were collected on the residents opinions of certain aspects of their lives,

surroundings and care in the nursing home. This was only based however, on fifteen minute interviews and it is not clear whether consumer views were ultimately included in the overall quality scores.

Validity and reliability

The decision as to whether quality exists and if so to what extent, depends on the validity and reliability of the criteria used. For example, it is important who sets the standards against which quality is to be judged. Criteria set by the profession itself may be quite different from those set by specialists in the academic setting, or by those concerned with regulation, as in the case of the nursing home industry.

Lewis (1973), considering the problems of process assessment points out that to overcome problems of reliability, relatively large numbers of observers are required where panels are applying `implicit' criteria for their judgements. Furthermore, lists of criteria formulated by different organisations may in themselves vary in length and complexity

(as in the case of guidelines produced for nursing homes by the various Health Districts). In respect of procedures based upon explicit criteria, the recording of information in the record is taken as an indicator of performance. The assumption that documentation is an aspect of quality of care does not take into account the varying time available for documentations. Records may be unavailable, inaccurate, incomplete or biased and they do not generally include any interpersonal contact information.

Threats to the validity and reliability of outcome measures also warrant examination. First, the timing of assessing outcomes is important. The longer the period of observation, the lower will be the connection between outcomes and the processes of care and the more difficult it becomes to draw conclusions about specific problems with the quality of care rendered by specific providers. This is a particular threat to the validity of mortality rates as a measure of quality of hospital care.

Secondly, is the question of patient-reported information and whether patients can provide relevant, reliable and valid information about the quality of their care. Noting the apathy that often predominates the residential lives of old people, Booth raises two questions with implications for the interpretation of residents' perceptions and experience: how far do residents mean what they say and how far do residents say what they think? (Booth, 1985). Booth argues that it cannot be assumed that psychological well-being is invariably a valid or appropriate measure of final outcome and that it is impossible to distinguish people's feelings about their lives from their feelings about their location. The decision to persue this method of data collection should rest on an examination of the purpose of the evaluation, the reliability and validity of the information obtained and the practical barriers to data collection; for example, obtaining informed consent and approval by providers and the costs of data collection.

Strengths and limitations of approaches

Whilst Donabedian pointed out that rigour and precision were lacking in quality studies, he nevertheless argues that present techniques have been successful in revealing a range of quality from outstanding to deplorable, and that reproducibility based on minimally structured approaches has been possible. In general he considers that most studies suffer from having adopted too narrow a definition of quality, i.e. the technical management of illness.

Although Donabedian maintains that outcomes are the ultimate validators of the effectiveness and quality of medical care, he cautions that they must be used with discrimination. The major considerations being:

1. whether or not outcome of care is in fact the relevant measure for a particular situation;
2. the possibility of intervening variables other than medical care influencing outcome.

A major difficulty with the end-result approach is the problem of longitudinal follow-up, i.e. lost

subjects, and expense. Further, many authors agree that an obvious weakness is the inconsistency of interpretation throughout the numerous studies.

In a discussion of the process versus outcome approach to quality measurement, McAuliffe (1979) argues that the most direct way of measuring quality is to determine whether acceptable care was rendered. Observing whether the patient had a good outcome as a result of the process would be a less direct method of assessment; outcome measures he argues are unreliable since they have rarely been subjected to empirical validation. The possibility that end results have determinants in addition to quality of care, in McAuliffe's view, creates a type of invalidity. The appropriateness of hospital crude mortality rates as measures of hospital quality of care is questioned by McAuliffe and he argues that variables such as socio-demographic circumstances are more likely to explain differences in patient mortality and morbidity than quality of hospital care. He concludes that different measures of outcome are not interchangeable and argues that a rationale

should be developed for selecting an indicator (single or composite index) appropriate for the quality measurement intended. He notes further that it is therefore unlikely that any structural or process measure will correlate highly with all outcome measures.

The use of death as an outcome measure does not appear to be particularly useful in deciding what to do when care seems deficient, and some difficult questions remain to be answered. For example, even if sufficient adjustment could be made for severity and case-mix, would enough information and variability across institutions remain to make mortality rates reliable and efficient indicators of likely problems with quality care? (Lohr, 1988). Lohr advises caution in the use of the application of mortality rates as outcome measures given the degree of uncertainty and debate.

In relation to nursing homes there are some fundamental problems in using mortality rates as outcome measures of quality. Given the prognosis of many nursing home residents, death is not an

unusual outcome, and therefore, mortality rates would not be expected to differ considerably by institution. In the somewhat different setting of residential care homes, Booth's study did use mortality rates as an oucome measure and found differences in rates of mortality between homes, with residents surviving longer than expected in some and dying sooner than expected in others, although no explanation could be found for this (Booth, 1985).

There are also considerable obstacles in the use of physiologic outcome measures - principally, the need to collect information by direct examination of patients, which can be invasive, stressful and costly. Additionally, in the case of the elderly, the presence of several serious co-existing conditions may mean that it is impossible to obtain a full picture of the quality of medical care rendered using only one or two physiologic measures.

Likewise, disability measures have little relevance for evaluating the quality of institutional care for elderly residents, as

activity limitations and days in bed are commonplace. Although health status measures also rely on information gathered from patients, they could be promising tools for quality evaluation, especially where linkages between process and outcomes can or have been established.

Kane and Kane (1988) discuss the difficulties of using other traditional indicators in long-term care, such as discharge rates. These are inappropriate as they are influenced, amongst other things, by the availability of places to which patients can be discharged. Even re-admission rates to acute hospitals may indicate different things; either the long-term care was inappropriate, or hospitalisation may be a sign of effective monitoring and follow-up.

Because of these difficulties, Day and Klein (1987) suggest the use of "negative outcomes", a system operating in New York, that will act as signals to the regulatory bodies for more detailed inspection. Bed sores, unkempt appearance of residents and the use of restraints or behaviour modifying drugs are some outcomes that might

indicate poor quality of care. This framework of assessment should not, argue Day and Klein, replace frequent inspections of process, i.e. how the patient is treated. There are however, certain limitations to this approach:

1. It assumes a relationship between process and outcome; the absence of negative outcomes does not however, necessarily imply good quality of care.
2. Knowledge of pre-existing conditions is required against which to measure negative outcomes that relate to changes in patient status, e.g. a patient may have been admitted with bed sores.

Furthermore, it is important not to overlook the possibility that other indicators of quality such as patient satisfaction exist. It is argued however, that aspects of care such as privacy, respect for dignity, and recognition of civil rights will be insufficiently reflected in measures of patient satisfaction (Kane and Kane, 1988). A combination therefore, of structural measures and direct observation of staff may be more appropriate indicators.

The relationship between measures of quality.

Many studies have sought to determine the nature of the interface between structural/process aspects of care and outcomes. Linn et al (1977) conducted a study to determine the relationship of nursing home characteristics to differential outcomes of patients placed in several homes. Validity was increased by evaluating outcome in terms of the goals or prognoses that were set at the time the patient entered nursing home care. Over half the nursing home variables (size, staff/patient ratios, etc.) were never associated significantly with any of the patient outcomes measured, ie. mortality (living/dead), change in functional status (improved, unchanged, deteriorated, dead), and location of patient (discharged, still at home, in hospital, dead). The one variable consistently related to patient outcome was the number of hours of care provided by registered nurses. Homes with more registered nurse hours per patient were associated with patient survival, patient improvement and patient discharge from the nursing home. Better records and meal services were also related to survival and improvement. Linn suggests that the two

variables found to be associated with patient outcome by the study may be indicators of an intangible quality such as the atmosphere of the home or the personalities of staff, rather than number of nursing hours or meals per se.

These findings are consistent with others that have found structural variables rarely correlate significantly with other means of evaluating quality of care. Research into the relationship between costs and quality of care has found a similar lack of correlation. Using seven social environment indicators, (regime, motor control, privacy, participation, interaction, homogeneity, continuity), to measure quality of care, Darton and Knapp (1986) concluded that high costs were not associated with high quality care.

Similarly, there was no association found between high costs and high quality of care in a study conducted by Bartlett and Snell (1988). A number of variables, including staff/patient ratio and the availability of a range of facilities such as lounge, shop, television and lift were used as indicators of quality of care. The provision of

many facilities by a home made little difference to the price charged and assuming that costs are carried through to prices, it was concluded that high costs were not associated with high quality of care.

Booth's study (1985) of the style of regime in residential homes and outcome of care defined in terms of changes in the personal functioning or survival of residents, also concluded that differences between regimes had no more than a marginal effect on the functioning of residents, and differences in outcome were unrelated to the characteristics of regime. Booth proposed four factors, independent of the way homes were run, that could account for the difference in rates of improvement and deterioration that he found between homes. These factors were the personalities and life experience of residents; the physical health of residents; residents' expectations of behaviour; the skills of the staff.

This discussion raises some important questions about the use of process and structural standards

as indicators of quality. What are they really telling us? Most structural, facility-based measures of the quality of care are intended to measure the capacity for the provision of quality of care, but do not necessarily measure whether the capacity is actually used. Despite the lack of empirical evidence to link structural/process measures of quality with outcome, Kurowski and Shaunhessy suggest:

> "there is a threshold level of process or structural quality below which a poor outcome is much more likely and above which the relationship between process (or structure) and outcome is less predictable."
> (Kurowski and Shaunhessy, 1985)

Other authors argue however, that processes bearing no relationship to desirable outcomes should not be mandated (Kane and Kane, 1988). If no relationship between observed patient outcomes and the process of care can be demonstrated, then specific guidance on how to improve the quality of care is not possible. For this reason it is crucial that further research is conducted to provide evidence of linkages between process and outcome.

It is known that structure, process and outcome are not the three distinct, mutually exclusive

aspects of quality of care, but are related by causal connections. Wyszewianski argues that:

> "From the perspective of quality assessment, the characterictics of health care resources - that is, the attributes of the structure - are of interest only insofar as they influence how care is actually delivered, the process of care. The clinical activities that constitute this process are themselves subject to scrutiny only to the extent that they affect the patient's health status, in other words, to the extent that they determine the outcome. Outcomes, in turn, are indicators of quality of care only if they are attributable to process and structural elements, rather than being the result of genetic, environmental or other factors." (Wyszewianski, 1988).

Economic conception of quality

There is one further indicator to add to this analysis of quality measurement. Doessel and Marshall (1985) offer a conceptual framework for analysing the quality of health care that brings together the dominant approaches in the medical literature and an economic approach that involves the 'wants satisfaction' theory of consumer demand. They point out that to define quality of care only in structural or process terms is to define it in terms of costs per unit of output. This implies that the higher the cost, the higher the quality of the product. In economic terms however, it is argued that costs should only be

calculated after standardising for the quality of output.

Outcome is also viewed in economic terms as a set of characteristics, and that in specifying them neither cost or patient satisfaction parameters should be included. Only after a set of health status characteristics has been selected should cost and satisfaction be introduced to the economic evaluation of the service argue Doessel and Marshall (1985). In the context of health, patient satisfaction is indicated by indifference curves, where high levels of satisfaction are indicated by high indifference curves and lower satisfaction levels by lower indifference curves. Given a choice for example, of different medical services, consumers will be influenced by relative costs of the treatments, budget restraints and level of satisfaction with the outcome, i.e. absence of pain and restored mobility.

There are limitations however, with the economic model. Of particular note is the assumption that patients' preferences have not been formed by the supplier and that the patients' preference

function is not subject to satiation. Other limitations are highlighted by Van den Heuval (1980) who argues that the economic model overlooks the fact that the health care industry does things to people rather than for people, and often choice is limited where there is insufficient knowledge of the complex system. In the case of nursing home services, if the consumer is dissatisfied with the quality of care offered, she might have neither the health/finance or advocacy to enable her to switch to another institution. Her position is vulnerable and she is to some extent captive once a choice to enter a particular home has been made. Furthermore the decision to enter a home initially was unlikely to have been made in circumstances where a full consideration of the options was possible. A crisis situation where relatives responded by finding the first available bed is often the scenario. Limited information and the demand on places limits the possibility of a real choice being made. Therefore, whilst offering another approach to evaluation of quality of care, economic theories on consumer behaviour also have their limitations.

Quality assurance

The ultimate goal of measuring quality is its improvement, although this does not always appear to be the subsequent outcome. A common observation in the literature and studies on quality assurance is that quality assurance seems to stall at the measurement stage. Despite conclusive evidence of deficiencies in quality of care in a range of settings, effecting the organisational change required has often been impossible. This is particularly true when there are implications for long-standing health policy issues such as equality of access, comprehensiveness of service and overall resource levels. The provision of new services or major redistributions between existing services are beyond the scope of many quality assurance programs, usually geared to dealing with the improvement of what already exists (Pollitt, 1988). Some authors argue that the lack of progress in quality improvement in health services in the United States can be attributed to a failure to utilize existing knowledge and past efforts (Wyszewianski, 1988). Even efforts to

adapt well established industrial quality assurance techniques to the health care field have been made in a piecemeal fashion and have not therefore provided much of an impetus.

Because the focus of quality of care has been on acute inpatient hospital settings, concerns about quality of care in other areas such as long-term care has been neglected. However, current community care policies aimed at reducing hospitalizations have led, in particular, to greater demand for long-term care. Wyszewianski (1988) argues that continued efforts to find ever better measures of inpatient care quality will divert resources away from quality improvement in inpatient settings and perpetuate the relative neglect that has characterized the study of quality in long-term care. The need to address issues of quality measurement and assurance in long-term care settings, such as nursing homes, is therefore becoming ever more pressing.

The effectiveness of the regulatory approach towards quality assurance has been questioned by reports in the U.S.A. Non-compliance with safety

codes, patient rights and level and standard of service continue to be noted. Kurowski and Shaughnessy (1985) attribute the limited success of Federal, State and peer review efforts in the U.S.A. to improve the quality of long-term care to a lack of knowledge of the measurement and assurance of quality in long-term care. Kane and Kane argue however, that that the failure to enforce quality standards is a failure of will and resolve rather than a technical problem (Kane and Kane 1988). They identify a number of factors exacerbating the difficulty:

1. the lack of differentiated sanctions in many states which leaves no option short of closing or decertifying a facility;
2. the lack of public resources to document problems and to prosecute offenders;
3. the lack of alternatives for residents in an environment with a limited bed supply;
4. the hesitation to disrupt residents;
5. general inertia.

Many similar factors appear to be currently affecting the enforcement of standards in nursing homes in the U.K. It is hard to imagine that many proprietors will be motivated to improve standards

above the minimum level required until the reimbursement system, i.e. payment of supplementary benefit funding in the U.K., is somehow linked to quality.

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CHAPTER THREE

CONSUMER EVALUATION AS AN INDICATOR OF THE QUALITY OF CARE

Models of Consumerism

It is only in recent years that it has become commonplace for users of health services to be referred to as consumers. To talk about consumers of health services, however, implies that someone has freedom of choice and the necessary information to exercise a particular choice, about whether for example, to select one nursing home over another. However, the position of most users of health services and particularly potential nursing home residents is that they are very old, chronically ill, and often needing a place urgently as a result of a crisis situation having arisen (Challis and Bartlett, 1987:89-103). The client is not usually the key figure in the initiation of care - it is more likely to be a relative or professional. To the extent that shopping does take place, consumers may be motivated to seek a lower cost nursing home, but

it is likely that they will have difficulty identifying lower-cost homes that will deliver care of an equal or higher quality than the consumer would otherwise use. General lack of any kind of information about nursing homes against which to assess them is a key factor here. Furthermore, once in residence, if dissatisfied, the consumer is unlikely to exercise the `exit' option (Hirschmann, 1970), given the circumstances and the difficulty likely to be encountered in finding another place.

It is clear that the popular use of the term `consumer' in the health care context differs significantly from the commercial concept of consumerism. This does not imply, however, that efforts to introduce certain elements of the commercial concept of consumerism into the health care context are impossible. There are even some small signs of progress in this respect. Winkler's view is that the key to any serious concept of consumerism is the principle of outside scrutiny on the inside working of the organisation (Winkler, 1987). This notion of outside scrutiny is contained in the four models that she proposes.

First, in line with the concept of community participation, is the Community Health Councils (C.H.C.s) model. Despite the numerous consumer surveys that have been conducted by C.H.C.s, the alliance of many of them with senior management limited their effectiveness to challenge conventional practices on the patients behalf. There has been little activity to date from C.H.C.s in relation to nursing homes, with one exception; Oxford C.H.C. has produced a comprehensive guide to all homes in its area for prospective residents and their families, giving details of charges, staffing, rights of residents, facilities, medical cover, etc. (Oxford Community Health Council, 1984). The guide avoids making recommendations or criticisms, but provides an ojective description of each home within its district.

Second, the democratic accountibility model argues for increased democracy through elections on to health authorities. The role of consumers in this model is however, unclear.

Third, is the user power model, which can be interpreted as complete consumer sovereignty through the marketplace. Winkler points out however, that a situation of collaboration with health care professionals may be more realistic given the major weaknesses with this model, which are that: 1) consumers may be too ill, old or mentally incapable to control their decisions; and 2) they are unlikely to possess the medical knowledge necessary to make decisions about their health care.

Fourth is the partnership model of consumer involvement in health care. This would require consumer organisations and the providers of health care to be considered as equal partners in the pursuit of high quality health care.

Since it is clearly difficult for users of health services as individuals to achieve very much, a number of strategies involving the setting up of institutional arrangements are necessary for empowering users (Winkler, 1987). These include:

- the availability of independent user information on service availability, delivery, accessibility and quality.
- the support of independent patient advocates with the power to influence policy.
- the availability of clinical audits that evaluate clinical performance.
- introduction of improved complaints procedures subject to outside scrutiny.
- participation of user representatives in committees where policy issues are decided.
- collective accountability of user representatives to a community group.

In relation to the first strategy outlined, consumer satisfaction surveys are just one of the means available for empowering the consumer and it is upon this aspect of consumerism that the discussion in the remainder of this chapter is based.

Consumer satisfaction and quality assessment

Consumer satisfaction surveys have become increasingly used over the last decade as

indicators of the quality of health care services. Views have been sought to assess the quality of medical and nursing care in a variety of settings: outpatient clinics, hospitals and group practices. Evaluations have been carried out at various stages - both during and after treatment or hospital stay. Since the Griffiths Report (1983) there have been over one hundred consumer surveys of inpatients (Carr-Hill et al, 1989) and most recently the White Paper `Working for Patients' (1989) prescribes the routine use of surveys to monitor patient satisfaction in the N.H.S.

Donabedian (1980) identified patient satisfaction as a factor directly influencing compliance with medical regimens and decisions regarding access to care. Such measures are often grouped with process or end-result of care, but the complexity of an individual's perception of care makes such labelling over-simplified. Lebow (1984) argued that the difference between `objective' aspects of care and patient perception of care justified quite separate consideration of the two approaches.

There exists considerable variation in the interpretation of the concept of satisfaction in the studies that have attempted to measure it. In a study of patients' satisfaction with their medical care, Lochman (1983) defined satisfaction as:

> "a positive appraisal by the client that the clients' goals and expectations regarding health care have been achieved."

Pelletier (1985) takes a broader view of the meaning of satisfaction:

> "The construct of patient satisfaction refers to an individual's attitude about the health service he is, or has been, involved in."

Pascoe defines patient satisfaction in a similar way, also commenting that satisfaction consists of both a cognitive evaluation and an emotional reaction to the structure, process and outcome of services (Pascoe, 1983).

Consumers can contribute to the definition of quality in various ways. First, they can influence what is included in the definitions of `health' and `health care'. This is important as it is believed that clients and practitioners have different views in this area. Secondly, consumers determine the valuations placed on the expected

benefits and risks to health. Thirdly, their values and expectations regarding the management of the interpersonal process influence definitions of health care.

Cleary and McNeil consider that self-reports of satisfaction may be useful for quality assessment for a number of reasons (Cleary and McNeil, 1988). First, patient satisfaction should be considered an integral part of quality of care. This is considered to be particularly important in helping identify situations in which communication between physician and patient is not optimal. Higher patient satisfaction may be a result of better patient-physician interactions in a number of dimensions. Secondly, patients opinions are important in assessing the risks and benefits of both the technical and interpersonal aspects of care, in addition to the amenities. Thirdly, satisfaction with care may be a direct or indirect indicator of outcome.

Sometimes satisfaction, per se, is not measured, but terms such as `attitudes', `beliefs' and `perceptions' are used to describe the measures

used to evaluate the providers and services studied. Such ratings can however be equally reflective of patient satisfaction. O'Sullivan commented:

> "Quality-of-life issues are of paramount importance in assessing satisfaction with care in a long-term facility. When patients expect to spend weeks, months or even years in a health care facility, factors such as food, noise level, and comfort and cleanliness of surroundings become major components of satisfaction with care." (O'Sullivan, 1983)

There are a number of factors found by various studies to be related to patient satisfaction. Socio-demographic characteristics, such as age, social class and race have been found to help explain patients' perceptions and attitudes towards care, although such findings are often inconsistent and contradictory. Of particular relevance to the subject of this research is that older patients tend to report higher satisfaction than younger patients (Locker and Dunt, 1978).

Attitudes and expectations concerning medical care have been the focus of many studies of patient satisfaction and again there is little consistency in the way patient expectations have been studied. Generally, however, expectations account for only

a small amount of the variance in patient reports of satisfaction with care (Cleary and McNeil, 1988).

The consumers assessment of quality can be obtained on the same dimensions for which professional assessment can be given, thus making it a valuable tool for evaluation and planning. It could relate to the settings and amenities of care; to aspects of technical management; to features of interpersonal care; and to the physiological, physical, psychological or social consequences of care (Donabedian, 1980). In other words consumer assessments can be applied to the structure, process and outcomes of care.

In relation to the structure of care, the organisation and financing, links with patient satisfaction have also been demonstrated, but many of these associations are poorly understood. Positive correlations have generally been found between patient satisfaction and accessibility and continuity of care. Negative correlations were found in some studies between waiting times and satisfaction ratings.

The processes of care, such as the technical competence of the provider might be thought of as especially difficult for the patient to evaluate. The perceived competence, intelligence and qualifications of the provider has been found, however, by some studies to be related to patient satisfaction. Perceived interpersonal and communication skills have generally been found to account for more of the variation in patient satisfaction; caring and sensitive physicians tend to increase patient satisfaction. Many of the studies link greater patient satisfaction with provision of information, counselling, explanation of payment plans, happy providers with favourable attitudes to patients/showing personal interest, time spent and nature of provider/patient communication. Caution should, however, be exercised in the interpretation of these findings, since the emphasis in the management of interpersonal relationships could be accounted for by possible consumer expectations that providers are already technically competent and othere characteristics therefore become important.

Ware et al (1978) identified four types of evidence relating to patient/consumer satisfaction that emerged from the empirical literature on patient satisfaction:

1. Psychometric studies (those focusing on measurement methods and issues) indicate that satisfaction is a multidimensional concept and that the dimensions are related.
2. Studies of relationships among questionnaire items hypothesized to measure specific satisfaction dimensions provide empirical evidence in support of the validity of patient satisfaction variables.
3. The usefulness of satisfaction scores as dependent variables in evaluation of health and medical care services is demonstrated by evidence regarding the characteristics of providers and medical care services that influence patient satisfaction ratings. However, little is yet known about validity of patient satisfaction ratings in distinguishing `art of care' from technical aspects of quality of care.

4. The concept of patient satisfaction appears to be related to health and illness behaviour.

Based largely on their review of surveys of patient satisfaction, Ware et al (1978) propose a multidimensional taxonomy of patient satisfaction comprising eight distinguishable dimensions, which constitute the major sources of satisfaction and dissatisfaction with care.

Relating to provider conduct are two satisfaction dimensions: the art of care and the technical quality of care. Accessibility/convenience and finances are factors involved in arranging to receive medical care and the receipt of care. The physical environment in which services are located, availability and continuity of care are three further major sources of satisfaction and dissatisfaction. A less frequent measure has been satisfaction with efficacy and outcome of care, i.e. improving or maintaining health status.

Methodological questions

Some of the more obvious limitations of consumer studies are noted by Goldberg and Connelly (1982). If studies are undertaken by the providers themselves, consumers might be reluctant to express their true feelings to the people who have tried to help them, and on whom they may have to depend in the future. Under the direction of providers, there could also be a danger that interpretations of findings might be biased when consumer opinions are not taken at face value or thought unworthy of serious consideration. Furthermore, the personal and confidential nature of some caring interventions may lead to resistance on the part of providers to examination and possible criticism by outsiders.

In 1978, Ware et al, undertook a major review of the literature relating to measurement of patient satisfaction. From a study of 100 articles and reports on patient satisfaction, Ware commented that reports:

1. Were lacking in reliability estimates, so it was not clear how much information was

actually obtained from the measures fielded and therefore difficult to draw conclusions about the significance of the relationships observed;

2. Relied on single-item measures to test hypotheses (multi-item measures scales yield more score variability and higher reliability and validity than single-item measures);
3. Had limited findings on the validity of satisfaction scores as dependent variables in relation to specific characteristics of providers and services;
4. Had questionable quality of data; there was insufficient reporting of, for example, missing data and return rates.

A major issue raised by Ware et al is whether satisfaction measures differentiate between specific characteristics of providers and medical care services, e.g. can measures distinguish between satisfaction with financial aspects of care and with art of care? Global indicators of overall levels of satisfaction may not be particularly useful for planning intervention or

making judgements about specific characteristics of providers and services.

Despite Ware's criticisms about validity, satisfaction data were frequently used (in 51 out of 81 empirical studies examined by Ware) to evaluate health and medical care services. The evidence available does support the hypothesis that patient satisfaction scores are valid dependent variables, ratings having been significantly linked to characteristics of providers and services.

A major problem underlying the majority of consumer studies and reports, as argued by Kelman (1976), is that most of the studies are still undertaken by providers of care in an attempt to evaluate the effectiveness of such care and to identify and rectify `unsatisfactory' programme elements. Certainly a major drawback has been that studies have not focused specifically on identifying consumer criteria for quality of health care.

Such critisms are echoed by Carr-Hill et al (1989) in reference to a patient satisfaction questionnaire developed with the support of the Department of Health by the clinical accountability, service planning and evaluation (CASPE) project at Bloomsbury. Criticisms included the use of only twelve short questions; lack of incorporation of patient concerns; the highly formalised approach; the assumption that satisfaction/dissatisfaction was unidimensional; the potential for response set acquiescence and the general lack of clarity about what was being measured. Carr-Hill warns that the intended use of the index of satisfaction as a routine method of feedback would be limited as it was unlikely to pick up the substantial variations in patient satisfaction, particularly over time. Doubt is also cast on the ability of management to absorb, interpret and react to a continuous influx of index numbers of this kind.

Consumer evaluation of quality of residential care

There are a number of problems involved in obtaining consumers' views of the quality of their

residential care. In the first place it can often be difficult to conduct an interview at all because of the chronic condition suffered by the resident. In Townsend's epic study of residential homes for the aged some difficulties with interviewing residents were noted, although useful strategies were employed for dealing with various situations:

> "A number of mentally and physically handicapped persons were able to answer only some of our questions. Rather than weaken our conclusions by leaving them out of the final analysis we sought every means possible of getting information about them. We wrote out our questions for those who were stone deaf. We talked to mentally handicapped persons quietly on their own and often were delighted to get patchy responses when they had not been expected either by the matron or by ourselves. We were able to check certain details, for example, about mobility and special disabilities, by personal observation; and we obtained information from the matron or members of her staff on questions of age, family, health and reasons for admission."
> (Townsend, 1984: 11)

Where interview schedules are used, certain types of questions have been found to be of limited use with the elderly. Clough, for example in his study of old age homes found multiple choice questions difficult to use:

> "For example with question 21 about the aims of old age homes, I wanted interviewees to select one of the four statements as the most important, or add others of their own. In fact

> hardness of hearing coupled with some difficulty in remembering all the items made it impossible to answer without considerable development of the question by me. This leads me to question the appropriateness of multiple-choice questions with old people, and, indeed, the reliability of evidence drawn from such questions." (Clough, 1981)

Obtaining an adequate sample can also be a problem when interviewing in institutions. The person-in-charge acts as a gatekeeper and in private institutions in particular, may refuse access altogether or strongly influence who will be interviewed. For example, Clough only managed to interview two-thirds of the residents in the home he selected for study (Clough, 1981). The rest either refused, were judged to be to ill by staff or were unable to speak.

Bland acceptance of their situation, or reluctance to criticise the institution or carers on whom they rely are further drawbacks to this approach. In their study of local authority residential homes, Willcocks et al commented that there was a tendency for residents to only approve what they were currently experiencing:

> "Residents having single bedrooms insisted that they had a preference for single bedrooms; whilst those occupying double rooms insisted that they preferred to share. Those who ate at a dining table for four insisted

> that four was the appropriate size; whilst those who ate at a dining table for six insisted that they preferred six."
> (Willcocks et al, 1982).

Again, problems of this nature can be overcome to some extent by the use of creative techniques such as the visual game used by Willcocks (1984). By illustrating different physical features on cards, residents were eventually persuaded to make choices over aspects of the environment which they felt were important. The top five choices were: 1. safeguards against fire; 2. Windows which you can open; 3. Easily opened doors; 4. A single bathroom; 5. Ordinary baths.

Another major problem is the possibility that residents' satisfaction may well be conditioned by their expectations of the institution. For many old people expectations may be very low indeed and possibly influenced to some extent by images of the old workhouse system and a consequent reluctance to depend on `welfare'. Booth suggests that psychological well-being cannot, therefore, be assumed to be an appropriate measure of final outcome, and comments that:

> "the encompassing nature of residential environments....makes it virtually impossible to distinguish people's feelings about their lives from their feelings about their location." (Booth, 1985:103)

One further related criticism of measures of well-being and consumer satisfaction is that they reflect not only residents present circumstances, but an accumulation of events, including their previous life in the community (Willcocks et al, 1987:138). Caution is therefore advised in attributing all negative feelings of well-being to the effects of institutional living.

Such considerations lead Booth to the conclusion that evaluation of quality of care is a safer and more practical approach than evaluation of quality of life. The main distinction Booth makes between the two concepts is that quality of life is defined in terms of both the characteristics of the environment and the individuals subjective response to them, whereas quality of care is measured by the comparative effects of different institutions, settings or regimes on the objective status of the residents. Booth questions, however, the validity of many of the scales measuring the objective status of residents, since they

originated in America, or were standardised on non-institutionalised populations (Booth, 1985).

Despite the limitations of satisfaction studies, recent works have continued to elicit the views of the consumer, and the feelings of the resident concerning their present lifestyle are becoming increasingly important to those concerned about quality of care/life in long-stay institutions.

Townsend's descriptive study was one of the earliest investigations into the quality of care and life in residential homes and during the course of the study 489 residents were interviewed using a structured questionnaire (Townsend, 1964). Questions covered a range of areas including home, family, physical health and capacities, occupations, social contacts, reasons for entering the institutions and reactions to the life it provided. The study revealed that although attitudes were determined to a certain extent by the type of home, all residents experienced to some measure, isolation from family, friends, community; difficulty in forming more than tenuous relationships with members of the staff and other

residents; loneliness; loss of privacy and identity; and collapse of powers of self-determination.

Willcocks et al (1987:126) used six variables as indicators of the feelings expressed by residents about home life and their current self-esteem:

. Adjustment to home life,
. Adjustment to ageing,
. Worry,
. Worried about aspects of home life,
. Dissatisfaction since coming to home,
. Staff satisfaction.

Significant associations were found to exist between all measures concerning residents. Satisfaction measures were found to associate positively with each other, but showed negative correlations with worry items. Attempts to identify residents' preferences for the ideal setting revealed preferences for aspects of the environment that were normal, unexceptional and non-institutional.

In a study of different care provision for the elderly, Wade et al (1983) also elicit the

attitudes of the elderly to their current situation. They conclude that patients/residents respond well to effective questioning and suggest that patient/resident responses reveal underlying basic attitudes which may be related to differences in organisation and which may have a bearing on patient outcome in terms of physical and mental dependency.

A further recent study of consumers' views of residential care was undertaken by Wilkin and Hughes (1987). Using semi-structured questionnaires, 60 respondents in Local Authority homes were encouraged to talk about the things that most concerned them. Areas identified as important to all residents were: passing the time, contact with the outside world, relationships between residents, organisation and staff. Overall evaluations were drawn from residents' reflections on life in residential care. This study really takes the form of an account of institutional life from the consumers' perspective which identifies specific aspects of life which might have been improved. Complaints of loneliness and boredom were the most consistent

features of the interviews. The study does not seek to measure satisfaction levels or attempt to rank order quality attributes with respect to their importance for the individual.

There is a promising sign throughout all these more recent consumer evaluation studies of progress and improvement in methodology. Some research in residential settings (Willcocks et al, 1987; Booth, 1985) is no longer generating the bland responses and lack of variability that was previously threatening the validity of using patient evaluation measures. Whilst such authors suggest that these evaluations should be used with caution, their studies are nevertheless providing some clear views from the residents of nursing and residential homes about their priorities for good quality care and the things that concern them.

If certain methodological problems can be overcome, consumers' views undoubtedly provide a useful assessment of the quality of care they are receiving. In homes where residents express feelings of boredom, loneliness, dislike of meals, fears of being too demanding, unhappiness with

their room mate, etc., questions have to be raised about the quality of care and the possibility of underlying problems in the management of a home. There is the likelihood that such issues are of more immediate concern to residents than the square footage of their sitting area, the location of the drug cupboard, or the display of a home's registration document. Consumer feedback could be used routinely to measure the quality of care in addition to the necessary structural and process standard measures and is, arguably, essential for the comprehensive evaluation of nursing home services.

In the case of regulations and guidelines for the nursing home industry, whilst there has been some attempt to address quality care attributes believed salient to the consumer, these have been viewed largely through the perspective of health care professionals and planners. As mentioned previously, there have recently been some attempts to elicit the views of consumers of residential care homes, but nursing homes are unlike residential care homes, and empirical evidence on what consumers of nursing home care regard as

being of importance to them is inadequate. Health Districts responsible for overseeing this sector have different interpretations of what constitutes quality of care from the social services departments responsible for private residential homes. Any further development of criteria and standards for the nursing home industry should have as its basis investigations of health care quality attributes derived from the consumer.

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PART TWO

METHODOLOGY

CHAPTER 4

QUALITATIVE METHODS IN POLICY EVALUATION

Qualitative research methods

There are widely divergent views with respect to the legitimacy of qualitative methods. Researchers from a positivist tradition assert that such methods are unscientific and can therefore only function in an exploratory capacity, prefatory to quantitative research. In addition to these assertions about its very legitimacy, qualitative research has some serious weaknesses and problems associated with the methods it uses, as documented by Miles (1983).

The collection of data is highly labour-intensive and demanding for the lone fieldworker. The transcribing of recordings, coding and analysis can become overwhelming, particularly as the methods of analysis are not well formulated. Despite such potential problems, qualitative methods were considered to be particularly suited to this study. The following discussion provides a rationale for the use of such methods and in doing

so answers some of the questions that concern researchers from other traditions.

The theoretical perspectives underlying qualitative methods depart from the quantitative approach which is enshrined in logical positivism, the dominant social science perspective in the twentieth century. The positivists seek the facts or causes of social phenomena and generally overlook the subjective state of individuals. Qualitative methods are derived most directly from the ethnographic and field study traditions in anthropology and sociology. Perspectives developed in phenomenology, symbolic interactionism and naturalistic behaviourism, ethnomethodology and ecological psychology have all had an influence on qualitative methods. Throughout these traditions is an emphasis on the "verstehen" approach or the subjective interpretation of human behaviour (Trūzzi, 1974).

A key feature of the qualitative research strategy is the inductive approach, which analyses the situation without imposing pre-existing expectations on the setting. Therefore, specific

observations are gradually built into general patterns. In contrast with experimental designs, which manipulate and measure the relationships among selected variables, qualitative methods allow the important dimensions to emerge from the analysis of cases under study and are "discovery oriented" (Lincoln and Guba, 1985). The concern is, therefore, in understanding naturally occuring phenomena in their natural setting and no attempts are made to manipulate the research setting.

Qualitative methods employ a number of field techniques including participant observation, in-depth interviewing, detailed description and qualitative field notes. The depth and detail provided by qualitative data emerge through direct quotation and careful description. In this way the respondents' level of emotion, experiences and basic perceptions are revealed in their own way of organising the world.

Issues in evaluation

Evaluation has been defined as:

> "the collection and analysis of information by various methodological strategies to determine

> the relevance, progress, efficiency, effectiveness, and impact of program activities." (Veney & Kaluzny, 1984:2).

Five approaches to evaluation are identified by Hogwood and Gunn (1988:228-234):

1. Before-and-after studies compare the situation in terms of relevant outcomes (individual or aggregate) after programme implementation with the situation before the programme was started.
2. Modelling focuses on the past and involves the construction of a programme model that incorporates programme outputs, lags and changes in other possible influences on outcomes.
3. The experimental method evaluates the outcomes of programmes in relation to the initial policy objectives by assigning randomly selected samples to an experimental group which receives the programme or a control group which does not.
4. The quasi-experimental method uses the non-equivalent control group, where individuals or groups with similar characteristics are assigned to a comparison group instead of using random selection.

5. Retrospective cost-benefit analysis involves the use of economic concepts to identify and measure the costs and benefits of programmes and policies.

Smith (1981:226) refers to a further approach named process evaluation in which programmes and policies are evaluated as they proceed.

In the various approaches described, quantitative methods have been the traditional model employed for evaluation research. Experimental approaches that emphasise cause and effect have been the norm with the underlying assumption that programmes are designed, implemented, evaluated and replanned in an ordered sequence of events.

The application of the experimental model has its limitations - a fundamental criticism is that true experimental evaluation is rarely attained. Various authors (Neigher and Fishman, 1985) have pointed out the limitations; these include a bias toward producing data that reject the null hypothesis, little encouragement of data with

pragmatic importance and a reluctance to describe data collection procedures in detail.

In addition to overcoming such methodological problems, to be successful experimental evaluation needs the trustful collaboration of legislators who establish clear goals. An executive which converts the legislative intents into specific programme guidelines is also necessary. A further requirement is for evaluators who develop adequate evaluative criteria from the programme objectives and are able to monitor implementation and effectiveness as well as examine the range of stimulated effects. Experimental evaluation cannot therefore be undertaken at any time; it has to be anticipated at the beginning of a programme.

Most problems for which evaluation research could be useful for policy-makers and clients are ill-structured, dynamic, and vary from client to client, and cannot therefore be separated from their context (Hellstern, 1985). Such characteristics support Britan's argument that programme evaluation can never be completely "rational" (Britan, 1981:46). Serious limitations

occur as soon as evaluation is concerned with the less well specified 'life' content of a programme.

Britan (1981) makes a basic distinction between experimental and contextual evaluation models. Unlike the experimental approach, contextual evaluations seek to understand programme complexity in particular settings. They also question the need for concentrating on manipulation to related assumptions and stress the importance of understanding and identifying the underlying assumptions which may lead to the definition of an issue and guide the motivation of the different actors and their interactions. No attempt is made to impose experimental controls upon the phenomenon being studied or to deal with extraneous variables.

Contextual models offer an important alternative to experimental evaluation because there are many attributes of programmes that do not lend themselves to counting. Programme quality or the effect of a programme upon the quality of life experienced by participants of the programme can

not be measured adequately by the scaling of quality.

Whilst the contextual model encompasses a variety of specific methods and approaches, Britan (1981:53) argues that its emphasis on the holistic approach makes it more compatible with qualitative methodologies. Other authors have, however, criticised the use of qualitatitive methods in policy evaluation. Mulhauser (1975), for example, argues that the goals of ethnographic research and policy research are incongruous for a number of reasons:

1. Length and complexity of typical ethnographic reports.
2. Limited basis for generalisation because of the small number of situations or institutions studied.
3. Unpredictability in substantive focus and depth of detail.
4. Descriptive and inherently conservative nature of studies.
5. Orientation toward global portrayal of a phenomenon and a resistance to partitioning it into specific problems,

6. Isolation from developmental hypotheses about cause and effect.

Patton (1980), however, identifies several situations in which qualitative methods are particularly suited to evaluation research. First, where outcome measures have not been carefully developed, it is more appropriate to gather descriptive information about what happens as a result of programme activity than to use a scale which is of questionable validity and reliability. A scale that measures self-esteem, for example, might be of limited use in detecting incremental changes in people whose self-esteem is already quite high. In addition, measurement scales developed in one setting may not be appropriate for another.

Second, there is often the need for an unobtrusive measure. Sometimes the administration of a standard questionnaire or test, or the collection of quantitative data would affect programme operations by being too obtrusive, and could have the effect of distorting the study findings.

Observation and informal interviews may be much less obtrusive.

Third, qualitative evaluation methods can be valuable for legislative monitoring. Legislative intent usually focuses on a certain kind of delivery system being provided, but often conceptualisations of legislative intent do not easily lend themselves to quantifiable specification, e.g. quality of care. The complexities of policy implementation in the delivery of human services can be monitored by detailed descriptions of how programmes are operating, for example, descriptions from clients about the nature of their experiences. This can help regulators to determine whether their own interpretations of legislative intent are being met. Better information is thus generated for decision makers and consequently they are more able to understand what they are doing, make more effective use of resources and feel more comfortable in decision making.

Any theories about what is happening in a programme are grounded in the programme

experience, rather than imposed on the programme. The individuals' experiences are not therefore delimited in advance of the fieldwork by combining unique cases, but generalisations may emerge later. In the experimental approach to evaluation, the approach is usually to enter the programme at two points in time - the pre-test and post-test. A treatment group is usually compared with a control group on a limited set of standardised measures.

In practice however, programmes are subject to change and redirection and evaluation tied to a single treatment would be meaningless in many settings. An evaluation that focuses on the actual operating and impacts of a programme over a period of time is more likely to document the day-to-day reality of the setting under study. The data can include outcomes, changes in treatment and patterns of action, reaction and interaction. Furthermore, lack of statistically significant differences do not mean that there are no important differences among people on certain outcomes, but that the differences may be qualitative rather than quantitative.

The evaluator, using a qualitative approach to measurement, seeks to capture what people have to say in their own words and describe the experiences of people in depth. The questioning is therefore open-ended in order to find out what peoples lives, experiences and interactions mean to them in their own terms and in their natural settings. Such an holistic approach is essential for a complete understanding of a programme.

Hellstern (1985) listed the ideas behind the qualitative approach as:

1. Getting close to the people actually doing and acting, and develop familiarity with the substance of their problems.
2. Focusing on their basic situations and acting role at different levels.
3. Delineating their interaction and strategies, tactics and argumentations.
4. Assembling and analyzing the abundance of episodes or events in terms of disciplined abstractions by judgements.
5. Studying the assumptions of argumentations of different actors and their different perspectives and motivations.

6. Comparing events and episodes with the argumentation and their assumptions.

The fact that qualitative approaches to evaluation are more likely to use participant observation and unstructered interviews does not diminish the accuracy of the data. Neither should it be of concern that qualitative analysis does not rely on ordinary statistical inferences; the inferences made are simply of a different type. Many strategies are available to ensure the reliability and validity of the data (these are discussed fully in the next chapter). For example, Hellstern advocates the use of triangulation of a variety of data-gatering methods e.g. participant observation, interviewing, analysis of documents.

Applying qualitative evaluation methods to the nursing home setting

In a comprehensive review of the effects of programmes and services for the elderly, Kane and Kane (1987) only report studies that have comparable control groups, interventions that actually took place, sufficient sample size to

generalise, appropriate and accurate measures, and those demonstrating completeness of follow-up. Although experimental designs are clearly more highly valued by Kane and Kane, they recognise that the outcomes studied in nursing homes fail to capture matters of concern to residents. They further acknowledge that satisfaction with the care and the environment may be the best "gold standard" of the effectiveness of a facility.

The development of controlled techniques to measure the quality of care is not only a difficult task, but assumes that the important variables are known and understood. Because of the lack of existing information on consumers views and perspectives of the quality of care in nursing homes, there is a particular danger that the questions formulated may impose the researcher's framework on the respondent and exclude considerations of importance to the residents.

Some of the difficulties of using quantitative approaches to the study of elderly people in institutions are evident in a number of recent research reports (Willcocks et al, 1987; Clough,

1981; Department of Community Services, 1986). They are particularly beset by questions of validity. For example, measures used to elicit consumers' views of nursing home care have demonstrated a tendency for residents to express high levels of satisfaction. This is hardly surprising considering the vulnerable situation in which many residents find themselves. The majority of nursing home residents are over 80 years old, chronically ill and in a very dependent position (Challis and Bartlett, 1987:89-103).

Oversimplified questionnaires that provide fixed responses to questions, weight client satisfaction on a scale, or record the numbers that are satisfied or dissatisfied, provide no understanding of the reasons behind the respondents opinions.

There are a number of other special challenges in relation to interviewing elderly residents that favour the choice of more qualitative approaches. These were identified by Schmidt (1975) as intermittant confusion, chronic confusion, dysphasia, problems of sight and hearing,

unwillingness, and overprotective nurses and relatives. Many of these factors will effect how certain respondents are able to perform on a particular day. If a flexible approach is adopted in which the researcher is prepared to return later, or on another day, rather than instantly dismissing the respondent as unsuitable, then more valuable data can be obtained. This approach requires time and is more likely to be achieved in the kind of in-depth study typical of qualitative research.

Since qualitative field techniques usually require the presence of the researcher in a particular site for long periods of time, some of the problems created by overprotective nurses and relatives can also be overcome. Once access has been obtained and trusting relationships developed between the nursing staff and researcher, then it is likely that the overprotectiveness will diminish. Also, other residents' participation in the study is likely to encourage those initially found to be unwilling to join in.

The quantitative paradigm alone is unlikely to reveal the complexities of nursing home life and the nature of relationships existing therein. The structured approach and direct line of questioning typical of the quantitative method would therefore have been unsuitable for this survey.

A more holistic and contextual model of evaluation was required that could reveal for policy-makers an evaluation of nursing home care grounded on the experiences of residents and identifying their concerns, preferences, priorities and views about the care they received. This is known as the `emic' approach in which the conceptualisations of a particular group are studied and categorised in the language of the "insiders" view (Parse et al, 1985:68). The interpretation of events from the informant's perspective is the important feature of this approach. Using such a qualitatively oriented approach in this study, all aspects of the problem could be explored and the underlying assumptions and attitudes examined within the context in which they occured.

Description of the qualitative evaluation design

As one of the objectives of the research was to compare the consumers' perceptions of the quality of nursing home care with the perceptions of the regulators and providers, a research design was necessary that was capable of gaining an adequate qualitative understanding of several perspectives. Whilst the focus was to be on the consumer's view, this alone was inadequate for the purposes of the study. A `pluralistic evaluation' was therefore adopted that enabled the collection of data on the interpretations and perceptions of `quality' in nursing home provision from various interested parties (Smith and Cantly, 1985).

To provide the kind of detail from which it is possible to present a picture of what it is like to be experiencing life in a nursing home setting, the descriptive mode of inquiry was employed (Artinian, 1988). This approach asks such questions as: what is going on here? What sorts of things make a difference? How does this experience compare with previous ones? How could the situation be improved?

Both subjective and objective data were obtained through in-depth interviews, analysis of organisational policies and documentation, notes on observations in the field, and fieldnotes on naturally occuring conversations in the field.

This research is intended to offer the policy maker a systematic interpretation of the experiences of the consumers of nursing home care so that decisions and actions can take into account the views of those likely to be affected. The study formulates policy recommendations from research that are based on an humanistic perspective. It provides a unique opportunity for the various interested parties to negotiate their competing perspectives about what constitutes quality of nursing home care.

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CHAPTER 5

RESEARCH METHODS

Fieldwork setting

The study was conducted during the months of March to July in 1988 and was confined to one district health authority and selected nursing homes registered in that authority.

Since health authorities have developed their own guidelines and interpreted the N.A.H.A. guidelines in different ways, the study aimed to represent as many perspectives on quality as possible in nursing homes in just one health authority. The focus of the study, consumer evaluations of quality of care, could therefore be fully explored in the context of the standards and practices developed and applied in the registering health authority. (Further details of the study D.H.A. are provided in chapter six).

Furthermore, the health authority selected had become well known to the author because of a previous exploratory study conducted in the City by colleagues in 1981 (Challis,1982) and a larger

study of nursing homes in the South of England during 1986 (Challis and Bartlett, 1987). During these years a cooperative working relationship had been developed between the local nursing homes and the University, thus providing the ideal climate for negotiating further research of a possibly more sensitive nature.

Sampling

As the purpose of the sampling in qualitative investigations of this nature is to include as much information as possible, maximum variation sampling was the sampling mode of choice (Lincoln and Guba, 1985). The aim was not, therefore, to define a representative sample from which generalisations could be made, but to select the sample in ways that provided the broadest range of information possible. The sample was consequently expanded until redundancy with respect to information was achieved, a point also known as `theoretical saturation' (Glaser and Strauss, 1967). It was not possible, therefore, to determine the sample size at the start of the study. However, plans were made for the

identification of at least the initial elements of, what would be, the final sample.

A major consideration in the selection of residents as informants was that they were located in nursing home facilities that varied in respect of their standards. Based on the knowledge already obtained from previous studies and discussions with nursing home inspectors from the D.H.A., five suitable homes were identified. Two homes did not meet the requirements of the N.A.H.A. guidelines (1985) - one in respect of its physical environment and the other in relation to staffing levels. Another two homes were considered to offer care of a very high standard, over and above the minimum requirements. A fifth home was selected as representing a fairly typical nursing home in the area, offering care of a consistently acceptable standard, but providing nothing that set it apart from other nursing homes. The five homes also differed in respect of their type of ownership, time established, size and location.

The matrons of the five homes were contacted by telephone and a meeting set up at each facility to

discuss the proposed research. They were effectively the gatekeepers, without whose cooperation it would have been impossible to access potential informants. An explanation of the study and its objectives was provided to each matron at the initial meeting and some preliminary feedback from the study's findings was promised when the interviewing was complete. Fortunately, all the matrons were happy to have the research conducted in their nursing homes and thought that it would be useful, although two did show some signs of anxiety about what the residents might say about their homes. Another matron considered that her home only had a few residents who would be 'sane' enough to cooperate with the study. At the conclusion of the study however, half of that home's residents had been successfully interviewed. Generally, the study was looked upon in a positive light, particularly because it was considered that the residents would enjoy having a visitor.

The cooperation of the matrons was sought in the identification of potential informants. As a primary consideration in selecting residents was

to capture the diversity of individual characteristics, a purposive sampling frame was used. Therefore, the potential informants listed embraced a wide range of social and personal circumstances; for example, age, sex, marital status, condition of health and length of stay. Age was limited to those sixty-five and over. There were some obvious exclusions from the study: confused residents and those with whom communication would have been too problematical; such as those with severe speech difficulties and total deafness, and those who were really too sick to be troubled by an interview.

A potential problem of being largely guided by the matron in the identification of possible informants was that in her concern to present a favourable image, residents thought to be too critical or troublesome might have been overlooked. Efforts to overcome this problem included the provision of clear explanations for the study and assurances that the information obtained would be used in a constructive way. The matrons were also assured that neither the home nor residents would be identified in the final

report. In addition, the almost unlimited access to each home that was achieved assisted in the participant observation and made it possible to become involved in the many aspects of home life. It was then possible to identify other informants not included in the initial listing.

Using the lists of potential informants, successive informants were selected in accord with the need to extend, test and fill in information, and the sampling process continued at each home throughout the study until there was no new information emerging. The final sample of residents totalled 46.

Obtaining consent

Throughout the sampling process, the elements of informed consent were addressed; namely, voluntariness, information and competency (Mansfield et al, 1988). A letter explaining the study and inviting residents to participate was distributed to all the potential informants through the matron (see Appendix 2). Shortly after the letters were distributed, the author

approached each potential informant, in the privacy of their own room where possible, so they would not feel compelled to participate as a result of staff pressure. Information concerning the study was discussed and the resident's competence to participate in the study was assessed before consent was obtained. The information was presented in a simple and concise fashion. It was emphasized that the study would be unobtrusive and would have no effect on the daily life of the resident. Residents were assured that they were not being singled out for the research and that the majority of the residents in the nursing home were being asked to participate. Assurances were also given that if residents agreed to participate, they would be free to withdraw from the study at any time and that anonymity and confidentiality would be preserved. Residents were then encouraged to ask questions regarding the study. Verbal consents were obtained and witnessed by a member of the nursing staff. The majority of residents readily agreed to participate and asked few questions. Appointments were usually made for the interviews, but often consenting residents were willing to be contacted

and interviewed at any time during the morning or afternoon.

Of the initial listing of potential informants, there was only one direct refusal for which no reason was forthcoming. Two residents were assessed to be incompetent to participate in the study or to give informed consent because of apparent confusional disorders. One resident was excluded because of her rapidly deteriorating physical health. Great amounts of patience, time and perseverence on the part of several residents and the author, enabled interviews to be conducted successfully with informants who had considerable speech difficulties and hearing problems. These were often the residents that nursing staff had considered to be unsuitable for interviewing.

Only one informant exercised her prerogative to withdraw from the study after the first interview on the grounds that she had nothing further to say that could be of any interest. Another informant died shortly after his first interview. However, the data from both of these informants was not disregarded as it was obtained early in the study

and was both detailed and useful, thereby contributing towards the development of the format for subsequent interviews and the eventual identification of categories and themes.

Procedure for collection and treatment of data

The approach taken in the interviews was an unstructured open-ended form of inquiry, characteristic of the anthropological style. In almost all cases the interviews were formal, i.e. prearranged, and conducted in the privacy of informants' own rooms. Where rooms were shared, an alternative private location was found when possible. All the interviews were conducted by the author; every informant was interviewed at least twice and some three times. The total interview time per informant varied from two to six hours. The sessions followed the open, free-flowing style favoured in the symbolic interactionist approach (Blumer, 1969). Generally, interviews were arranged to fit in with the routine of the home and resident, and therefore, mainly occured during the morning or afternoon. Early mornings and mealtimes were avoided, unless there was an

invitation to stay. Each home was visited on various days of the week and at different times of the day, so that all shifts, except the night shift were covered. Because of the intensive nature of the interviewing, only two, or occasionally three interviews were conducted on the same day.

The early interviews were unstructured and more like `guided conversations' (Schatzman and Strauss, 1973) or interactive interviews, as the salient dimensions of the topic could not be identified until several informants stories were heard and the analysis begun. A brief interview guide was formulated (see Appendix 3) and generally, the first interview provided the orientation and overview necessary to obtain sufficient information on what was important to follow up in detail later. An open atmosphere in the interviews aimed to have informants speak in detail about their own experience in order to clarify what they meant. The questions guided informants to disclose what they thought the author should know (Spradley, 1979). Interjections usually consisted of asking the informant if they

could give an example to illustrate a point they had made. The control of topics was carefully avoided by using open-ended questions in non-specific language, thus the informant's terms were identified and defined.

The interview generally began with a discussion about the nature of the author's interest in nursing home life. This was often the only impetus needed for informants to launch in to a narrative about their various experiences. Otherwise, a useful starting point was to question how the informant came to be in a nursing home; this sometimes prompted the detailing of major life events and provided an invaluable background against which to analyse other information. Another question that enquired about a typical day in the nursing home sought to discover what concerned informants on a daily basis, as well as what made a day or event special and how this event was defined by them individually.

The structure of the interviews increased with the number of completed interviews. The second and subsequent interviews persued in depth the

elements determined to be salient by the informants and took a more direct approach in following up specific detail.

Consistency of interviewing was sought to allow for comparisons between and among informants (May, 1989). This was not achieved by asking the same question of all informants, but rather by asking as many informants as possible those questions that appeared important at a particular point in the data collection. This helped inform subsequent interviews. Consistency was further aided by the continual review of transcripts of previous interviews and careful preparation for subsequent interviews.

The proceedings were tape recorded with the permission of the informants. They were assured that the recordings would be destroyed as soon as they were transcribed and that they would not be heard by anyone else. None of the 46 informants objected. The machine used was compact and battery operated and the informants soon forgot its presence. On only one occasion did an informant ask for the machine to be turned off. This was at

a particular point in an interview when he was criticising his family and felt that his comments were too damning to have them recorded. It was possible to resume recording once the informant had concluded his comments on that subject.

Notes were also made after each interview on the nature of the interaction. They covered such things as: whether the informant was relaxed, wary, confident, nervous; if there had been any interuptions that upset the flow of the interview; the overall impression on how relevant and meaningful the interview had been. These notes helped in the subsequent interpretation of the data by adding important contextual material.

Staff interviews

The matron of each home was interviewed at the start of the study; in each case the interview was carried out in the privacy of an office. On two occasions the husband was also present and provided a contrasting perspective to the discussion. A number of topics were explored that related to quality of care: attitudes to caring

for the residents; the key elements of high quality care; priorities in the provision of nursing care; difficulties faced in the provision of high quality care; factors that enhance the residents' quality of life; maintaining standards that complied with the requirements of the regulatory authorities; and strategies for promoting quality nursing practices in the staff (see Appendix 4). On subsequent visits to the homes, further opportunities were also presented to carry out informal conversations that enriched the initial discussions.

Discussions of a very exploratory nature also took place with various members of the nursing staff. It was not the intention of this study to conduct staff interviews with the same degree of intensity appied to the residents' interviews. Informal conversations were, therefore, conducted with as many nursing staff as possible, as and when opportunities presented themselves. In total, the views of 41 nurses were obtained on a range of topics relating to quality of care. One quarter (10) of these were qualified, and the remainder were nursing assistants.

The nursing staff had generally been made aware that research involving the residents was being conducted, but the project's objectives were explained more fully to every staff member interviewed. The interviews usually consisted of short conversations as these were possible to fit around the nurses' duties. The data were obtained by talking to nurses as they prepared meals, made beds, or took a short coffee break. The one exception was nursing home D, where the staff development programme provided an ideal venue for meeting nursing staff and hearing their views. One two hour session was entirely given up for the author to talk about the project and this provided valuable and uninterrupted time for those attending to explore their views and perceptions about the quality of nursing home care.

The encounters with staff were, out of necessity, more directed than the interviews with residents. Staff were asked what attracted them to this kind of nursing, to define their main responsibilities, to discuss the constituents of quality care and their major satisfactions and dissatisfactions with the job (see Appendix 4). Note-taking was the

method employed for recording the data, as the tape recorder was found to be extremely inhibiting. To lessen the anxiety that any form of recording seemed to create, notes were usually made up as soon as possible after each encounter.

Informal interviews were also conducted with the health authority officers responsible for registration and inspection of nursing homes. Views were sought on: the existing guidelines for the nursing home industry; experiences of monitoring standards; enforcement of standards; and conceptualisations of the quality of care. (See Appendix 5). One officer was also accompanied on a nursing home inspection.

The living arrangements found in the nursing homes were such that the majority of the resident's day was usually spent in the confines of a bedroom. Much of the staff/resident interaction therefore occured out of view and staff interruptions tended to be minimal during the interviews. It was therefore difficult to achieve the level of participant observation generally expected for a full ethnography. However, useful observational

data was obtained from time spent `lurking' in corridors, waiting in reception areas, occasionally sitting in residents' lounges and watching the activities in kitchens and in the dining room. The length of time spent in each home was sufficient to observe many of the daily activities and routines as they occured. During the course of the study, observations covered the same time periods in each of the homes, excluding the night shift. All observations and impressions were recorded daily in the form of a field diary.

Analysis of data

Approximately 1,000 pages of interview transcripts were generated from interviews with the forty-six residents, the nursing home proprietors and various nursing staff and the health authority nursing home inspectors. Analysing the data obtained from the nursing home residents presented the main challenge. The task with this data was to translate it into a form that would facilitate an accurate, complete description of the quality of nursing home care from the residents' perspectives. Data from the other sources were

much less copious and also more condensed as note-taking was the method of recording rather than tape recording. Also, fewer informants were involved and the same degree of in-depth interviewing had not been possible as with the nursing home residents. This part of the analysis was therefore more straightforward and less time-consuming.

The data were analysed in a systematic fashion to determine any emerging patterns and build categories that had as their base the concepts of the research participants, an approach based on that developed by Glaser and Strauss (1967). It was also recognised, however, that the emerging categories would be influenced to some extent by the author's sensitizing concepts and would necessarily reflect the relevances of the research. Inevitably, connections were made with existing theories and concepts about the area of investigation and before the detailed analysis was commenced a certain amount of 'focusing' was necessary, which involved thinking about the broad research questions. The formation of categories in advance to data analysis was

carefully avoided, as this could have had the effect of prematurly closing developing lines of inquiry.

The entire descriptions were read at least twice to get a sense of the whole experience, its themes and dynamics, and to examine the data in more detail. Statements that appeared to be particularly important to the informant were underlined on duplicate copies of the transcripts; for example, expressions that conveyed strong preferences. The process of developing coding categories was commenced by noting in the margins potential themes/categories that the statements seemed to fit. A record was maintained of the criteria used in applying coding categories to the data. From this record a codesheet was developed with the criteria for applying each category, in order to ensure consistent application of the final coding categories.

During this initial stage of analysis, notes were also made about any inconsistencies in the data, and the reasons for this assessed. Greater revelation and honesty during the course of the

interviews, a change of attitude, or genuine inconsistency were some of the possible causes of contradictions. Also noted were places in the interviews where potential leads had been missed, or where it was likely that the data had been influenced by 'over-probing'.

After completing this initial phase of coding, the data in the form of statements, were extracted and entered onto colour-coded index cards which were arranged in the allocated categories. The colour-coding was devised so that the categories of data and the nursing homes could be easily identified. The exact words of the informant were used as much as possible to avoid severing the connection with the original description. When this process was complete, the statements were studied to identify any duplications of the same expressions. Such statements were then eliminated.

The clusters of statements were then referred back to the original descriptions in order to validate them. A re-examination was carried out if anything in the original was not accounted for, or if the cluster proposed anything which

was not in the original. They were then clarified or elaborated by relating them to each other and the whole. The content of categories with similar labels was compared and then sometimes condensed into one category if the theme or topic was clearly related. Throughout the process, notes were made about the relationship between categories as they were being constructed.

The process of comparison resulted in the arrangement of broad organising domains that brought together similar categories and then sub-categorisation beneath these. The index cards were coded appropriately. Six major domains were identified that reflected broad topical areas and the sub-categories reflected narrower topical areas within the major domains. The categories were descriptive, rather than conceptual, keeping in mind the nature of the study. Descriptive matrices that summarised the data were constructed (Miles and Huberman, 1984). These reflected the sub-categorisation of each category across all subjects, thus making it possible to review all data from a given subject across the sub-categories.

The final analysis of the data required many returns to the interview transcripts for clarification and contextual information. The final categorisation was reviewed and transformed into language that reflected the major domains of care being described.

The coded data were rebuilt into a thematically relevant whole. The descriptions of the content of each of the major categories were constructed from summaries of the pertinent sub-categories and provided the basic working documents for organising and drafting the study results.

Finally, a further level of analysis was conducted to identify similarities and differences among the categories. This level of analysis identified additional relationships from the informants comments that did not seem to cohere with the organising framework, yet provided further insights into the meaning of quality of care from the informants perspectives.

Validity and Reliability

It is as important to address questions of validity and reliability in qualitative research to demonstrate the credibility of the findings, as it is in research that employs quantitative methods. Whilst issues of reliability and validity overlap in many ways, it will be apparent from the following discussion that in spite of separate treatment here, the two issues are very much related.

Both the internal and external validity of the research was considered and strategies adopted for dealing with potential problems in this respect. The study's internal validity, that is whether the research actually observed or measured what it was thought to be observing and measuring, was strengthened in four major ways (LeCompte and Goetz, 1982). First, it was likely that a close match between the derived categories and the real world of the informants was achieved because of the length of time spent in the facilities selected and the opportunities that were provided for continual data analysis and comparison. Second, the interviewing techniques used allowed

the emerging data to reflect the categories of the informants. This is rarely achieved by the instruments used in other research designs. Third, because the study was conducted in a natural setting, it reflected the life experience of participants more accurately than contrived settings. Fourth, all phases of the research process were subjected to continual questioning and reevaluation by the author.

Based on the threats to internal validity identified by Denzin (1970), ways to reduce such threats were considered. A major problem with studies of this kind is that the very presence of the researcher may distort both the behaviour and the verbal responses of the informants. Informants may provide information in the interviews that they think is the preferred social response. Omission of relevant data and deliberate misrepresentation are also potential problems. In this study, there was a possibility that the nursing home proprietors may put on a temporary show to reveal themselves in the best possible light. The credibility of the data obtained had therefore to be considered. The possibility of

such artificial responses occuring was reduced by spending a sufficient length of time in the field, but not long enough to run the risk of saturating the setting to such a degree that no further new data were revealed.

In addition, independent corroboration from multiple and different sources helped to sort out any distortions in the data and improved the credibility of the findings and interpretations. This technique is described by Denzin (1978) and is known as triangulation. In this study it was achieved by conducting multiple interviews with each informant and obtaining different sources of the same information. For example, when certain descriptions of home life given by informants appeared to conflict with the descriptions of other informants, the details were checked out by observational methods and also by conversation with key staff involved in different aspects of the home life, including the cleaners, kitchen staff and handymen, in addition to the nursing staff. Once a pattern of distortion was discovered it was then possible to correct the information coming from that source.

Other means employed included the establishment of appropriate relationships with informants. The importance of achieving objectivity as far as possible was acknowledged, however, a position of neutrality was not aimed for as this might have affected the quality of the data. Some kind words, assisting informants with small tasks before the interview, or sharing afternoon tea and biscuits did not, in the authors view, threaten objectivity. Such human behaviour appeared to facilitate a more open, honest and candid interview. Relationships with informants tended to become symbiotic in nature and it did not seem unreasonable for the informants to derive a certain therapeutic value from the exercise. The emphasis was on respect for the participants and the development of a trusting, reciprocal relationship. New paradigm research (Reason and Rowan, 1981) is based on this assumption, the goals of which are "understanding rather than control and liberating changes rather than maintenance of the status quo" (Connors, 1988).

There was, however, a fine balance involved in relationships formed with the informants. It was

natural that informants wanted to get to know the author, indeed it was a rarity for many to receive visitors at all. Often they wanted to know about the other homes involved in the research. Whilst it was appropriate to empathise with informants - this was often necessary during the discussion of sensitive topics - interviews proceeded without the author passing judgement.

Throughout the study, the status of the relationship between the informants and the author was monitored by making a detailed description and analysis of situations involving both observation and interviewing. Records were kept of any preconceptions held by the author before the study and changes that occured during the course of the study were also noted. Such considerations are acknowledged to be important in qualitative field research, since the 'self' is the major instrument for data collection (Lipson, 1989). The quality of the data can only be improved when the reasearcher has a grasp of his or her influence on the interaction.

Several days were allowed to elapse between interviews with the same informant to provide a respite period for participants and a period of reflection for the author. When informants were interviewed over a reasonable period of time this also helped to establish the stability of the information obtained.

The possibility of researcher-induced distortions appearing in the developing categories was reduced by seeking participant reaction and confirmation throughout the interviewing. Feedback was provided to the informants on second and subsequent interviews by summing up the major points that had arisen during the previous interview. Some preliminary feedback of the authors initial impressions was also provided to each matron, and comments invited as to the validity of the data.

Bias and distortion in the selection of informants was reduced by obtaining data from as many of the resident types as possible, since it is not the purpose of sampling in qualitative studies to obtain a representative sample. This process was

discussed more fully above in the section on sampling methods.

The external validity is usually referred to as the generalisability of a study's findings to a wider population. Since the methods adopted in this study did not include the usual criteria for findings to be generalisable, such as random sampling, the aim was therefore to achieve comparability and translatability of findings.

A clear description of the characteristics of the subjects and the categories generated during the analysis, provides a basis for comparison with a wide range of residents in other nursing homes. The issue of translatability was addressed by providing a detailed account of the methods and analysis and an explicit description of the characteristics of the categories/themes generated.

The multi-site design of the study addressed the problem of external validity to some extent by increasing the sample size. However, the reactive observer effects discussed previously as threats

to internal validity, equally threaten external validity when cross-group comparisons are conducted. It was therefore important to ensure that the groups were observed in a comparable manner. For example, longer periods spent in one setting would have increased the reactive observer effects in that setting over the others. Efforts were therefore made to balance out the time spent in observation equally between the homes.

The reliability of the study, that is the extent to which it could be replicated, was established in a number of ways. First, the question of external reliability was addressed. This refers to whether the independent researchers would discover the same phenomena or generate the same constructs in the same or similar settings (LeCompte and Goetz, 1982). Because of the highly individualistic nature of this study, it is likely that the research approached rather than achieved external reliability. An important consideration was the social role adopted by the author as researcher during the data collection. Whilst it could be argued that similar findings would not be obtained by other researchers unless they adopted

a similar role, the results generated from the study were nevertheless legitimate in that they contributed to the total picture of life in the nursing home setting.

The issue of the social context in which the data were gathered was also considered to have an important bearing on the content of the data and the replicability of the study. As the presence of others was likely to have affected what informants said, the interviews were conducted with each informant in privacy. Of course, it was still possible that informants were inhibited to varying degrees by being a part of the environment that they were being asked to evaluate. Attempts to address this problem are discussed earlier in the methodology section of this chapter.

Threats to external reliability were further addressed by reducing the chance of informant bias. A detailed description was provided of the process involved in the selection of informants and of the characteristics of those who provided the data.

Specification of the methods of data collection and of the methods of data analysis was as detailed as possible to further enhance the possibilitity of replication. A full description of how the constructs were developed, and explanation of the final categories, reduced the dangers of idiosyncrasy, and therefore, increased the chances of comparability.

The internal reliability refers to the degree to which other researchers, given a set of previously generated constructs, would match them with data in the same way as did the original researcher (LeCompte and Goetz, 1982). Inter-rater reliability is a key determinant of internal reliability. The standardised protocols for its establishment are, however, designed with structured observation instruments in mind. Their use would therefore have been inappropriate for participant observation.

Threats to the internal reliability, were therefore, reduced in other ways. In the analysis of data for example, low inference descriptors were used, i.e. verbatum accounts of information

provided by informants and narratives of behaviour and activity. The use of a tape recorder increased the accuracy of such transcripts. The descriptors provided were then used to substantiate the categories presented in the analysis of the data. This was done by providing rich excerpts from the transcripts in the results section of the report.

In addition to the total recording and transcription, the use of multiple methods of data collection, for example, in-depth interviews and participant observation, helped to improve the reliability of the data. The confirmation of results across the different sites further supports the reliability of observation.

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PART THREE

THE FINDINGS AND DISCUSSION

CHAPTER 6

A PROFILE OF THE STUDY LOCATION, SITES AND INFORMANTS

THE DISTRICT HEALTH AUTHORITY

The nursing homes selected for the study were located and registered in one English District Health Authority (D.H.A.). In line with nationwide trends, there has been a substantial increase in private nursing home provision in the selected health authority; in 1981 there were just seven private and voluntary homes for the elderly providing 188 places (Challis, 1982). This increased to 15 homes and 378 beds in 1984 (Challis and Bartlett, 1987). At the time of the study, registered nursing homes for the elderly totalled 25 and provided a total of 610 places.

For every 1,000 of the elderly population aged 75 and over in this health authority, it was estimated that, in 1987, there were 15 private nursing home beds (Challis and Bartlett, 1987). This figure was approaching the number of elderly long-stay N.H.S. beds for the same year, calculated to be 25 for every 1,000 of the health

authority's population aged 75 and over (Challis and Bartlett, 1987).

The D.H.A. served a wide area and was responsible for the registration and inspection of nursing homes situated in a number of counties. Ten of the homes registered in this health authority were located either in, or on the edge of the City; five were situated in small villages just outside the City, and 15 were in town and country locations throughout two counties. The homes were typical of the national scene and varied in their type of ownership, size, location, building and length of time established.

Married couples owned thirteen of the homes and the wife usually acted as the matron. Registered companies owned ten homes and the majority of these employed matrons to be responsible for the nursing care. It was this category of home that had particularly boosted the number of nursing homes in the D.H.A. in recent years. Religious orders ran two of the homes as non-profit making concerns.

Registration and Inspection

There were three officers involved in the process of registration and inspection of nursing homes. A senior nursing officer had the power to register and deregister nursing homes. The inspection responsibilities were divided between two other senior nurses; one position was part-time and the other full-time, but also involving other responsibilities for quality assurance in nursing services.

The statutory inspections were always unannounced and took place twice a year, although they were more frequent if considered necessary. The inspection could take up to three hours and went ahead whether or not the matron/owner was present. The N.A.H.A. checklist (1985) was used as a guide to inspection and a full copy of the report was subsequently sent out to the home concerned. If the report was unfavourable, the proprietor was invited to discuss any problems with the appropriate officer. Informal inspections were also conducted and arranged to suit the nursing home concerned.

At the time of the study, the health authority was developing its own standards to guide inspection and consultation with the nursing home proprietors was being invited. In a seven page document, `achievable' standards relating to the physical environment of the homes, personal services, nutritional service and nursing service were specified. Homes were expected to be making progress towards achieving these standards if they had not already done so. One of the health authority officers had also prepared a short guide for nursing homes to assess the quality of residents' lives (see Appendix 6). This focused on ten areas considered to be indicators of the quality of life. It was also proposed that residents would be routinely surveyed using a standard structured questionnaire to elicit their levels of satisfaction with the service provided. A complaints register had also been set up recently to ensure that complaints about nursing homes from any source were dealt with effectively.

Unlike the practices of many other health authorities, nursing homes applying to be categorised for terminal illness were not refused.

This enabled homes to charge more when an elderly resident receiving Supplementary Benefit became terminally ill. It also meant that homes were in a better position to accept terminally ill patients, as they could charge the higher limit allowed by Supplementary benefit.

The health authority had recently refused to renew the registration of a nursing home in its jurisdiction and as discussed in more detail in the following section, this case became the subject of an Appeals Tribunal. The outcome of the tribunal was the renewal of the home's registration, subject to certain conditions. The D.H.A. was criticised by the tribunal for presenting evidence relating to a period of several years, during which time staffing levels were considered inadequate by the authority, but registration had nevertheless been granted. In its defence, it was the view of the health authority that the legislative support and resources to enforce standards had been lacking in the past.

Those responsible for the registration and inspection of nursing homes considered that their

role was advisory and not one of policing. The working relationship with the homes was, in their view, satisfactory. In cases where there were problems, however, they felt powerless to do anything.

THE NURSING HOMES

Home A

This nursing home was an elegant Georgian mansion situated in beautiful countryside four miles outside the City. It stoood in twelve acres of outstanding gardens and grounds. Because of this position, there were no local amenities available, nor any form of local transport. Registration as a nursing home for 37 patients was first granted in 1983. Membership of the Registered Nursing Homes Association (R.N.H.A.) had never been applied for, as the financial outlay was not considered worthwhile by the matron.

The home was registered in the name of a limited company, consisting of seven directors and a number of shareholders. The directors included a

bank manager, accountant, insurance, builder, solicitor and G.P. Recently the matron was also made a director. The company recently opened a new nursing home under the jurisdiction of a nearby D.H.A.

The residents were mainly accommodated in comfortable, single and well furnished rooms with modern bedroom suites and a wash basin. Many rooms had their own bathrooms and all rooms had extensive views over the gardens, a telephone, provision for a television and a call system. During the time of the study, three rooms were shared, one by a married couple. One of the rooms accommodated four residents, although it was only registered for three by the D.H.A.

The residents were of varying degrees of dependency and included from time to time short stay and convalescent patients. A few of the residents would probably have been cared for more appropriately in a residential home. Approximately ten were described as very confused, a lower number than previously. The matron commented that the demand was such that they could

go completely "psychogeriatric", but this would probably create problems with staff recruitment; she therefore endeavoured to achieve a balance. This was, however, difficult at times because it was not the home's policy to move existing residents on if they became confused. Referrals were from a variety of sources: local N.H.S. and private hospitals, G.P.s and word of mouth.

The public areas for the use of residents and their visitors included a reception area, a dining room and lounge. Although the brochure advertised a billiard and bridge room, it was evident that these were not in use at the time of the study. The home was fully carpeted and well decorated. Some particularly stunning features inside the home were the beautiful original paintings, chandaliers and oak staircase. Outside in the grounds was an orangery, croquet lawn and ample car parking facilities.

There were facilities for meals to be taken in either the dining room or residents' bedrooms and an attractive printed menu was provided each day.

The kitchens were spacious and well kept and a full-time cook prepared the food.

The fees ranged from £250 to £450 per week, which included hairdressing and chiropody, but residents had to finance any additional services such as physiotherapy. A local General Practice served the medical needs of the residents, for which there was no charge to the residents or home. The majority of residents paid for their nursing home fees by private means.

The staffing levels were in accordance with the regulatory requirements. Qualified nurses were paid £4 per hour and cleaners £2.50. Conditions of service were very favourable and comparable to the N.H.S. rates. All nursing staff were in full uniform and presented a very professional nursing image. It was a preference of matron to recruit more mature nurses, or those interested in commencing nurse training and this contributed to a stable staff.

Training and education of nursing staff was not provided in a formal manner by the home; new

assistant nurses were usually teamed with a qualified nurse to begin with. Otherwise, education consisted of the occasional day course on incontinence, or some similar topic, provided by the D.H.A. The matron recognised the need for training and education to be more specific to nursing homes and was interested in developing a programme between the nursing homes in the area.

Before commencing at nursing home A the matron had managed her own nursing home for ten years and still maintained a financial interest in it. Her role as both matron and director involved her in all aspects of the home's management and she divided her time between the company's two homes. Initially she had lived in a flat at the nursing home with her husband, the company secretary, but moved away to obtain more freedom. She described her position as a very demanding one, which required her to be on call for 24 hours a day. She considered that there was now a need for two matrons, but commented that suitable ones were difficult to find. Matron tried to see the residents every day but did not always succeed

because of the increased demands made on her time by the other home.

The general atmosphere prevailing in this home was more formal than homely, although the setting was extremely peaceful. Residents did not appear to mix, the majority remaining confined in their rooms. There were no signs of any regular activities. The nurses would not have looked out of place in a hospital setting. The home was exceptionally well kept in every way. Visitors were free to come and go, and a full-time receptionist, who provided a useful source of information and help, was positioned in the entrance hall.

Nursing Home B

This home was situated in a pleasant residential area a short distance from the city centre. The house was originally a family residence built in the Victorian period. It was purchased by the present owners in 1981 and granted registration as a nursing home for eleven people. This was increased to eighteen places in 1984 following the

buiding of an extension that provided a further eight single rooms on two floors and the appropriate bathroom and toilet facilities. The home was registered for twelve residents at the time of the study. Membership to the Registered Nursing Homes Association had been applied for, but turned down.

The residents were mainly very dependent and immobile and 50 per cent were described as confused. The majority spent their days in the communal lounge/dining area, where the television was usually switched on. Others remained in their bedrooms which were bright, well decorated and basically furnished, each also having television. The home did not provide activities on a regular basis, or services such as physiotherapy, chiropody and occupational therapy. Neither, at the time of the study, did the home possess any wheelchairs; it was therefore impossible to take the immobile residents out locally, or even into the garden.

The owners were a married couple and until recently, the wife had been acting as the matron.

Prior to opening the home, she had been a senior nursing officer. The owners also owned a residential care home nearby.

During October 1987 this homes was the subject of an appeal at the Registered Homes Tribunal. Registration had been refused by the D.H.A. on the grounds that the premises had been inadequately staffed, that all shifts were not covered by Registered Nurses, and that unregistered second floor rooms had been used to accommodate patients. The appeal was upheld on the condition that the current owner would no longer occupy the position of matron and a new full-time Registered Nurse would be appointed to that position.

The nurse appointed to the position of matron had previous experience in nursing home care and welcomed the challenge presented by her new position, despite the home's poor reputation. She complained, however, that the owners would not allow her complete autonomy over either nursing or administration. The owners had recently admitted a resident who, matron felt, the home could not cope with, but the owners had not consulted her before

admitting the resident. The matron claimed that she had made a number of suggestions to improve the home's image, but none of them had been taken up by the owners. Towards the end of the study, the matron's dissatisfaction increased and she resigned, after only six months. No arrangements were made to hire a replacement immediately.

The nursing staff were young and unqualified and earned only £2 per hour. This factor probably contributed to the high turnover of staff. There were often difficulties finding replacements from the nursing agency. No training or induction programme was provided by the home.

The overall impression gained initially was that this home was clean and tidy, friendly and quite homely. The new matron had provided a stability that was clearly beneficial. However, towards the end of the study a deterioration was apparent. A strong smell of urine became evident and the cleaning did not appear to be so thorough. With the resignation of the matron and impending staffing difficulties, it was possible that this

home would experience another period of declining standards of care.

Nursing Home C

This was the most established home in the study, its history dating back to approximately 1916. The home was situated almost in the heart of the City in a five storey Georgian town building.

The owners, a husband and wife with a young family, took over the home in 1981 and eventually expanded into the house next door, increasing the registration to 25 residents. The wife acted as matron and the husband conducted the administrative matters and general maintenance.

In addition to being the most established, this home was the most deficient in terms of its physical environment and contravened the N.A.H.A. guidelines in numerous ways. Although the accommodation was arranged on five floors, no stair lift was provided. Neither was there a lounge or dining room and at least two bedrooms were well below the regulation size. The decor

looked shabby and the furnishings were old. The bathrooms were cramped and without lifting equipment. The small back garden had recently been landscaped, but did not appear to be used by the residents. In spite of its obvious deficiencies, this home was a member of the Registered Nursing Homes Association.

Residents were mainly dependent and immobile and spent their days confined to their bedrooms. There were no activities provided by the home, or routine services such as physiotherapy, occupational therapy and chiropody. Neither was there a choice of menu available.

The recruitment of nursing staff was an ongoing problem and staff turnover was high. The assistant nurses were paid £2 per hour and received just two weeks annual holiday. The arduous working conditions at this home were well known by the local pool of nursing staff. No training or induction programme was provided by the home for new staff. The shortage of qualified staff meant that the matron worked long shifts and was on 24 hour call. The owners were hoping to have their

first holiday for some years, but were having difficulty finding anyone to take over from them. Towards the end of this study standards of care were suffering considerably as a result of the staffing problems.

Nursing Home D

This home was run as a voluntary concern by a religious order and was first established as a surgical nursing home in 1942, and became a nursing home for the elderly in 1960. It was situated in a small village about three miles from the City.

The main part of the home was a magnificant old building situated in extensive gounds. There was a small annexe in the grounds that housed three additional residents who were able to do more for themselves. An extension was added in 1975 increasing the total registration to 43 beds. The home was also a member of the Registered Nursing Homes Association. Attached to the nursing home was a convent which housed the sisters, some of whom worked in the nursing home.

The dependency level of the residents was mixed, most were either frail or ill and a small number were confused. Everyone was accommodated in single rooms with a pleasant outlook and well furnished with modern bedroom furniture or some of the residents own possessions. Most residents had their own telephone and television.

Several communal areas were available in this spacious home, including a dining room, lounge, and reception area. A number of services operated regularly: occupational therapy, chiropody, hairdressing and, of course, Mass several times a day. Although this was the most tranquil of all the homes, there always seemed to be a certain amount of activity and people visiting at all times. In addition, a number of residents regularly sat or walked in the gardens.

The matron was a young sister of the Order and had been in the post for six months. Whilst she did not have a high profile with the patients, she was responsible for a number of innovative practices during her short stay, including the introduction of a staff training programme. She was also

planning to introduce a staff appraisal system. At the end of the study, however, this matron left suddenly causing considerable upset amongst both the staff and patients. She was especially liked by the staff who found her very approachable. Feeing unable to cope any longer with the stressful nature of this position was one of the reasons given for her sudden departure. An older sister, who had worked at the home some years previously, took over and was spending time getting to know the patients.

Recruitment of staff was not a problem and there was a balanced mixture of young and more mature nurses. Many of the nurses had worked at the home for a number of years and had obviously developed close relationships with some of the residents. The new staff training course was a great success and highly valued by the nurses, many attending the sessions on their days off.

There was an emphasis on privacy and respect for the individual in this home, and the training programme was intended to further develop the caring skills of the nurses.

Nursing Home E

This home was a pleasant detached character residence situated at the top of a hill about one mile from the City centre. A regular bus service stopped at the front door of the home. The home had a pleasant back garden and a duck pond and gardens were within walking distance.

The residence was purchased and registered as a nursing home in 1983 for ten residents by the current owners. Subsequent extensions increased the number of places to twenty, and further plans to extend would add a further seven bedrooms and improve the kitchen, lounge and dining facilities. The owners, a husband and wife team, were shortly to open another, larger nursing home some distance away and were also developing other health care business interests locally. The wife operated as the matron and the husband handled the administrative affairs of the home.

The majority of the residents were reasonably mobile and needed only minimal assistance with daily activities. In the view of the nursing

assistants, at least six out of the twenty residents could have managed in a residential home. Accommodation consisted of pleasant, light and appropriately furnished single rooms. A dining room and two lounges were provided and generally the more confused residents were situated together in one lounge. Only a few of the more dependent residents remained in their rooms during the day.

This was the only home that included a regular chiropody, physiotherapy and hairdressing service in the weekly fees, which ranged from £220 to £275. Activities such as occupational therapy and outings were not provided.

The matron was a friendly and open person with a wide nursing and hospital administration experience. Her day-to-day involvement in the nursing home had diminished in recent months, as she prepared for the opening of a new nursing home, but an experienced and reliable deputy managed the home in her absence. There were no problems with staff recruitment, staffing levels conforming to the health authority's requirements.

The only kind of staff training was again the occasional day seminar at a local hospital.

Overall, there was a pleasant, relaxed atmosphere in this home. It conformed to all the regulatory requirements, the nursing care appeared to be of a satisfactory standard and there had been no major problems with the operation of this home since it opened. It was possible, however, that with the impending expansion, the homely atmosphere might be somewhat difficult to maintain.

THE RESIDENTS

Demographic data

Between one quarter and a half of the resident population in each of the five homes was interviewed (Table 1).

Out of a total of 46 residents interviewed, eight were male and 38 female. The age range was sixty-five to ninety-seven. Ten of the female residents and one male had never been married, three were married and the other 34 were widows and widowers (see Table 2).

Table 1. Total residents and number interviewed

Nursing Home	No. Residents	Sample
A	37	11
B	12	6
C	43	11
D	25	9
E	20	9
Total	137	46

Table 2. Age Distribution of the sample

Age range	Number residents (male)	(female)
65 - 69		2
70 - 74	1	-
75 - 79	1	5
80 - 84	2	5
85 - 89	-	14
90 - 94	3	11
95 - 99	1	1
Total	8	38

The high average age of the informants meant that the close relatives and friends of one third (15) of them were no longer alive and these people did not therefore receive regular visits.

Nine of the residents had lived in the home for a period of less than six months and eight for a period of six months to one year. Four residents had lived in their nursing homes for more than five years; nine years residence was the longest period (Table 3).

Table 3. Residents' length of stay

Length of stay	Number residents
less than 6 months	11
6 months to 1 year	8
1 to 2 years	15
2 to 5 years	8
5 years or more	4
Total	46

The informants were admitted to care from a variety of settings; the most common route was from the resident's own home (19). Ten of the residents came directly from hospital and a

further ten from either a nursing or residential care home. Five informants had been living with a family member, usually a son or daughter, before their admission. Sheltered housing was the previous location of two of the informants (Table 4).

Table 4. Resident's location prior to admission

Location	No. Residents
Own home	19
Hospital	10
Residential home	7
Relatives home	5
Nursing home	3
Sheltered housing	2
Total	46

The majority of the informants were fairly dependent. In 12 cases the principle cause of admission was a cardiovascular accident, varying in degee of severity, but usually having resulted in the loss of use of limbs and partial loss of speech. A further 15 were severely handicapped as a result of arthritis, Parkinson's disease,

multiple sclerosis, incontinence, amputation of legs, or a fractured hip. Where there was an apparent absence of a physical diagnosis, in fourteen cases the resident's state of health was described as `frail.' The principle condition of two informants was blindness and one resident was said to be confused.

The people participating in this study were unique in many ways, but shared common characteristics that set them apart from other age groups. The majority were born at the turn of the century and had therefore known two world wars; displayed in many rooms were photographs of a friend, spouse, or brother in military uniform. The years of the depression meant that many had also experienced job scarcity and times of financial hardship. Personal experiences of looking after seriously ill loved ones at home were also common. The days of the workhouse were easily recalled and such memories may have been important influences on their views and expectations of residential care.

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CHAPTER 7

THE NURSING HOME EXPERIENCE: CONSUMERS' PERSPECTIVES

FINDINGS (1)

Introduction

The informants' descriptions revealed the wide variation of experiences of life in a nursing home. Analysis of the transcriptions generated six major categories that were grounded in the meaning of their experiences. They are expressed first in the language of the informants:

1. How I came to be here,
2. What the nursing staff do for me,
3. How I occupy my time,
4. What the home provides for me,
5. How I am adjusting,
6. The cost of care and how I pay.

These constituents of the nursing home experience were transformed into language that reflected the major domains of care being described (Table 5). The domains and their included terms are presented in Appendix 7.

Table 5. Major categories of the nursing home experience

1. ADMISSION TO CARE	How I came to be here.
2. CARE GIVEN BY THE NURSING STAFF	What the nurses do for me.
3. SOCIAL ASPECTS OF CARE	How I occupy my time.
4. INSTITUTIONAL CARE	What the home provides for me.
5. ADJUSTMENT TO CARE	How I am adjusting.
6. FINANCIAL ASPECTS OF CARE	The cost of care and how I pay.

ADMISSION TO CARE

The descriptions of nursing home life did not just revolve around the period after admission, but encompassed the period of time from when nuring home care first became a possibility, through the period of waiting to enter the home and on to the initial phase of adjustment in care. Generally, informants recalled the circumstances surrounding their admission, including who had made the arrangements, in some detail. The key elements of this category were the admission arrangements, circumstances of admission, factors affecting selection, preparation for admission and initial reactions (Table 6). Even when admission had occured some years previously, that this life

event was remembered with such clarity and detail, indicates the uniqueness and importance that individuals attached to it. In almost all cases informants commented that their admission had been inevitable, as no other alternatives were available.

Circumstances surrounding admission

Feeling unable to cope on their own any longer was a major reason given by informants for their admission, and this was related to a variety of events. Chronic illness, death of a spouse, removal of close family, unsuitable housing, or reduced capacity to perform the normal activities of daily living, were the kinds of situations perceived to have precipitated informants' admission. A combination of problems might have existed for some time and admission was finally triggered by an accident, as a male resident explained:

> "My wife died in 1981 - then I came to live with my son's family. I fell down the stairs and injured my back. I started to have spasms. My legs started getting bad and I couldn't walk. They were having difficulty at the shop and I needed everything doing for me, so that's why I came here."

Table 6. In-depth analysis of category: admission to care

ADMISSION ARRANGEMENTS	Family member	
	Professional	- Doctor - Nurse - Lawyer - Social Worker
	Self	
CIRCUMSTANCES OF ADMISSION	Unplanned/ crisis	- Death of spouse - Illness - Carer unavailable
	Planned	- Increasing frailty - Wish to avoid burdening family
FACTORS AFFECTING SELECTION	Location	- Convenient - Peaceful
	Recommendation	- Previous residents - Neighbour - Family
	Attitude of staff	
	Type of house	
	Fees	
PREPARATION FOR ADMISSION	Meeting with matron	
	Room inspection	
	Tour of home	
INITIAL REACTION	Negative	- Traumatic - Frightened - Lonely/lost - Anxious - Reluctant - Imprisoned
	Mixed feelings	
	Positive	-Thankful/ lucky

A further situation triggering admission was the declining ability of their carer or spouse to cope, or sometimes their reluctance to continue caring because of difficult circumstances:

> "I'd given up my home - I had been living with my niece for a time and then I think her husband rather objected to having anybody else there and so she found this place for me."

Admission to a nursing home was also perceived as the only alternative to becoming a burden on the family. A feeling of rejection was sometimes the result, as the following comments from two male informants indicate:

> "I do have something to complain about - that is being stuck in here. The problem is my family don't want me - well I think so."

> "The reason for my son putting me in a nursing home is to leave them free to carry out their own lives. Sometimes I feel I'm being neglected - but that's unfair."

The route into care was not always direct and in recalling their admission, informants detailed the intervening stages between leaving their home and entering the nursing home. This was often via hospital, a residential home, sheltered housing, or sometimes after having lived for a period with

a family member, as the following informant related:

> "I was in hospital and then I came back to the bungalow. Then one day, my son came and he said you'll really have to give up. You can't be here by yourself - I was living alone you see. He said you'd better sell up and come with us, and I stayed with them for eighteen months.Then I thought I'm holding them back. So I decided I'd come into a home."

Admission arrangements

The views of family members featured highly in the decision-making process involved in relocation. Informants usually commented that their admission was initiated by a member of the family. Others who influenced the decisions of many informants and their families included various health professionals, lawyers and social workers.

It was unusual for prospective residents to choose the particular home themselves; ill-health particularly limited the involvement of informants. The judgement of the third party involved was therefore relied upon to find a suitable place. Informants seemed conscious of others' efforts on their behalf and consequently felt obliged to go along with the final decision.

Care arrangements were sometimes decided upon without informants' knowledge or consent and the permanence of their situation was not apparent until later, as this informant commented:

> "I didn't know I was coming here... I thought I was just coming for a long weekend."

When there had been a lack of involvement in the selection process, the final outcome was particularly frustrating for informants:

> "I wouldn't have had it - our George sent Sue to look at it. To tell you the truth I wouldn't leave my home - chuck it up - to go and live in no nursing home."

Where doctors were involved in the admission arrangements, informants felt obliged to enter the prescribed nursing home, as illustrated by the following resident's comment:

> "The Doctor at the hospital said that I shouldn't live alone and suggested that I should go into a home - he said I'd have to, if I didn't want someone to live in with me."

Arrangements made without full consideration of the capacity of the resident to pay also caused great concern to those affected. One informant was directed to convalesce in nursing home A (the most expensive home in the study), a decision she

played no part in, with substantial financial implications:

> "The Doctor from the hospital told me I was to go here - I didn't know where it was - I'd never heard of it. Had I been to see it, I'm afraid I'd have said I could never afford it. I had no idea how much it would cost. I'm writing to the bank now because I'm overdrawn and drawing money out from my Building Society to cover it."

It was unusual for informants to have visited the home before being admitted. If a visit was made, informants commented that the arrangements were practically made by then. Recollections of visits to the home constituted little more than a brief meeting with the matron, described by one lady as a talk on the running of the home.

Factors affecting selection of home

Where third parties had selected the nursing home, the major factors perceived by informants as having influenced the decision were proximity to relatives or the resident's previous home, or sometimes more fundamentally, the availability of a room. Important factors positively affecting the choice of the two larger homes, were the atmosphere, the peaceful environment, the

outstanding buildings, and the kindness of the nursing staff. The gardens were a great attraction for residents in these homes, as the following comment illustrates:

> "It was the garden that attracted me in the first place. I could have gone into a flat, but flats don't have gardens and I like to do all my own gardening. I told the sister when I was interviewed that I was afraid of becoming bored coming from such a busy life, so they gave me my own bit of garden, so it's a great interest."

The fees were sometimes a major consideration for informants. One person did comment that in selecting his home, he took into consideration the amount of money he would have left after paying the fees to buy the occasional present for his family.

Initial impressions

Admission to a nursing home was generally not a very positive experience. Terms such as "traumatic", "strange", "terrible" and "inevitable" were used to describe the initial feelings. Informants' expectations of nursing home life differed; often they had no idea what to expect and wondered what they were going to see.

Negative expectations were common; one informant imagined "people sitting all around like a lot of crows."

A particularly lasting upset was the loss of home and informants recalled this event with a great deal of sadness:

> "I had to make a great decision to sell the house - that of course was a great upset."
>
> "Of course it's traumatic - one never gets over selling ones own home completely."

The loss of possessions evoked similar emotions. The speed of many relocations meant that the majority of personal possessions were disposed of by family, friends or a legal representative. On reflection, informants regretted that they had not kept certain items and many were unaware that they could bring their own things in with them. Informants pondered the whereabouts of their treasured items and described them in great detail, sometimes even picturing where they would have placed them in the room.

> "Breaking up my home was the worst thing about coming here - I gave other people everything I'd got."

One ninety-eight year old, interviewed on her third day of residence, was attempting to minimise the sadness she felt at her recent loss of home and possessions, and commented philosophically:

> "I feel I've just given everything up - this life is over really. I've tried to look on things as lent - after all, you've got to give things up, so you might as well give them up now as when you die."

The loss of freedom described by informants recalling their relocation was a common experience. Even for the very sick, feelings of no longer being in control of the most basic everyday events had an immediate impact. Choosing and cooking ones own food, controlling the indoor temperatures, opening windows, and generally following a pattern of life not dictated by others, were significant losses felt immediately upon admission. The following examples illustrate these sorts of losses:

> "I didn't like it too much at first because I'd never been in a home before and I'd always been free. I missed being out in the garden - I always did the gardening and all my own work. I knew every flower and stone in the garden."

> "I missed my independence straight away, especially having done thirty years in the army."

Contrasting with these views were a few more positive accounts of the first days in a nursing home, particularly from informants who had spent long periods of time in hospital. One informant suffering from multiple sclerosis, who had been in institutions most of her adult life, commented that the nursing home was much more personal than hospital and that she felt lucky to have secured herself a place.

Also, those who believed they had made a rational decision to enter a nursing home were generally more positive. An active 86 year old believed that prior planning was essential to ease the adjustment process:

> "I knew this place some years ago as I'd been brought here for tea in the garden. It was then that I decided that if necessary I should like to spend my last days here. I was isolated where I lived, so when I got old and couldn't drive the car, I decided well this is it. It's so stupid to leave it until you have to go into a place. If you've done no planning, it comes as an awful shock and takes a long time to settle in."

For one 91 year-old lady who had served as a first aid nurse during the First World War, nursing home A was described as the "Ritz", compared with the "stink hole" (nursing home B) from which she had

been removed. This informant related at length the incidents of neglect, incompetence and cruelty she had witnessed and had been subjected to for three and and half years, before finally being removed by the Health Authority following the discovery of her untreated fractured arm.

Entry to a nursing home did not mean instant companionship and social fulfilment for the new residents. The communal life was unfamiliar and could be strange for many as the following comments illustrate:

> "I felt very lonely in the beginning."
>
> "I felt terrible when I first came here - everything was so strange. Everybody seemed to know everybody."
>
> "I felt terrible when I moved in - but I thought it was only for a short time. I felt so lost."
>
> "When I first came I went to the sitting room with the others. The T.V. was on and I'd get a 'yes' or 'no' answer and that's all there would be to it. They'd just sit there all dead silent and I thought I'd rather have my own confinement."

Two new residents - husband and wife - described how exhausting the experience of moving had been. This was something that the nursing staff had seemingly not fully appreciated:

> "They're always on at me, saying that you must come down for lunch and meet the other people, but we're not ready for that yet. Not many people have to pack up a house and move from a hospital to here all within a week."

The process and nature of admission to a nursing home was included in the informants' descriptions and was clearly an important dimension of their total experience. The individuals' characteristics, family relationships, perception and understanding of this event shaped their response. However, from an analysis of the descriptions a number of common themes emerged.

First, entry into a nursing home is a complex process that involves a lengthy period of adjustment for the elderly person, commencing before entry is made and continuing for an indefinite period of their residence. Secondly, there is little real choice or control exercised by elderly people during their admission to a nursing home. Thirdly, upon admission, the resident immediately experiences a range of losses.

Table 7. In-depth analysis of: care given by the nursing staff

TECHNICAL CARE	Technical competence	- Techniques
	Training	- Reg.Nurse - Care Assistant
	Experience	- Time at home - Previous experience
	Care given	- Lifting - Dressing - Pressure areas - Bathing - Washing
ART OF CARE	Attitudes/ qualities of nurses	- Positive/negative
CONTINUITY OF CARE	Care from same nurse	
	Staff turnover	
AVAILABILITY OF CARE	Numbers nurses	- Staff shortage
	Impact on care	- Delays - Perceived neglect

CARE GIVEN BY THE NURSING STAFF

The care given by nursing staff was an important focus of the informants descriptions and was therefore defined as another core category. The dimensions extracted from the descriptions included management of care, the art of care,

technical care, availability and continuity of care (Table 7).

Art of care

One of the most significant factors emphasized by informants was the attitudes and qualities of the nurses caring for them. For the purposes of this analysis, this factor has been defined as the art of care.

A key figure among the nursing staff was the matron. She was regarded with respect and her position viewed by informants as one of the highest authority. There were also a number of expectations attached to her role from the informants' point of view. It was considered important for matron to have daily contact with residents: "I think that matron could just come round and say 'Hello, how goes it today'- well you don't see her." A common criticism made by informants was that they did not see the matron enough. The sight of matron delivering the post or bringing around coffee was taken as a sign that the home must have been short-staffed, so unusual

some residents thought it was to have a visit from her. Communication with the matron was a problem at times. When informants needed to see matron, a few resorted to writing a letter or asking their relatives to contact her.

Involvement of the matron in other nursing home projects meant informants saw less of her than they used to and this was perceived as a loss of interest. At nursing home E informants were clearly unsettled about the rumour that matron was opening another nursing home some distance away. In many ways this was taken as an indication that she cared less for them and that her involvement in their home would be diminished. This was also the case at nursing home A, where informants commented that since the second nursing home opened they had seen much less of the matron, and that in their opinion standards had fallen:

> "I think matron has a busy time - she's very good. I don't think she did the right thing to move away - not from my point of view. Things aren't done the same - the personal touch is missing - it isn't the same class of hotel. I used to think it was lovely, but I think it's quite ordinary now. Little things like mustard isn't put on the table and if you ask for it you'll get it sometime tomorrow. When matron was here, all those things were done."

The matron at nursing home D had been recently appointed. Informants commented on her relative youth, her inexperience with older people and the difficulty they experienced in getting to know or even see her. The long-standing residents fondly referred to the previous matron to whom they had developed an obvious attachment. Towards the end of the study at this home, the matron unexpectedly left one day. In spite of the criticisms that had been previously expressed, the informants were clearly shocked and upset by this event.

If there was a complaint or worry, informants indicated that they would usually talk to matron first, although because informants were mindful of compromising their position, this communication was not always as frank as it might have been. At the end of a series of highly illuminating interviews one informant commented:

> "They'll probably say that I've been very free with my talk, I don't know how I shall explain that I've talked to you for so long. I don't know what the matron would say if she knew I'd told you so much. It's good that you could get in. With the matron over us I wouldn't like to say anything that was detrimental."

Whilst the attitudes and qualities of the matron were important to the informants, so too were the attitudes and qualities of the nursing staff caring for them. Initially, residents tended to talk in very general terms about the nurses and were not directly critical. They often referred to them as "wonderful", "lovely", or "very good." As the interviews progressed, greater insight about the characteristics of the nurses was provided. The descriptions contained two elements; residents perceptions of the nurses' qualities (positive and negative) and the qualities they considered to be desirable. (See Tables 8, 9, and 10).

Table 8. Residents' preceptions of nurses' positive qualities

Friendly	Gentle
Understanding	Dedicated
Patient	Sweet/lovely
Kind	Obliging/willing
Helpful	Easy-going
Respectful	Pleasant
Interested	Amusing
Sense of humour	Wonderful
Caring	

Table 9. Residents' preceptions of nurses' negative qualities

Careless	Moody
Inconsiderate	Bossy
Nasty	Rough
Cheeky	Slow to respond
Lazy	Inattentive to needs
Tactless	Rushed
Ignorant	No time to talk
Cruel	Unwilling to talk
Rude/Bad-mannered	Unable to converse
Self-pitying	Rough
Disinterested	Forgetful
Abrupt/sharp	Unkind
In it for the money	Bad-tempered

Table 10. Qualities residents desired in nurses

Friendly	Cheerful
Understanding	Careful
Patient	Gentle
Kind	Prompt
Helpful	Chatty
Respectful	Maturity
Interested	Soothing
Sense of humour	Long-suffering
Caring	Approachable
Pleasantly spoken	Trustworthy
Attentive to needs	Sympathetic
Thoughtful	Personal touch

Overall, informants identified many positive qualities in the nursing staff; kindness, helpfulness, patience and understanding were just some (see Table 8). Specific examples were sometimes given that illustrated these qualities. A 76 year old ex-school teacher with speech difficulties following a stroke, commented:

> "I'm very conscious that I have at last got a home where the nurses treat you with respect - at other places they think that because you have difficulty speaking you must be daft."

The obliging nature of certain nurses was commented upon when they performed extra tasks such as shopping or setting hair. Generally, however, the descriptions were rather short on illustrations of the positive qualities identified. It was more common for positive comments about the nurses to be qualified; for example:

> "They're all very kind - mind I don't upset them. I don't ask for much to be done."
>
> "They're all very nice, but you only see them when they're doing something for you."
>
> "They're good girls and they'll do anything for you - mind you've got to go with them if you know what I mean."

It is likely that the nurses were automatically perceived as having certain qualities because they were providing care and the relationship was thus one of gratitude for the services rendered. The nurse's job was seen as a difficult and demanding one and informants were often prepared to overlook imperfections in the standards of care they received.

The descriptions were dominated by examples of negative qualities of nursing staff and incidents that demonstrated these shortcomings (Table 9). Virtually every informant made at least one unfavourable comment about a nurse or nurses caring for them. These perceptions provide a most illuminating insight into the impact of the attitudes of staff on the quality of care from the residents' perspective.

An almost universal source of concern was that care was delivered in such a rushed fashion. The following comment highlights the differing pace of the resident's and the nurse's life:

> "I think there's too much rushing in the morning. They get me undressed so fast that I think a lot of the girls don't understand that we need a little more time - just to take care with ordinary getting up."

This lady went on to explain that she had to make her selection of clothing the night before in order to save time in the morning, but when the day came, the clothes were often unsuitable.

Another informant commented that she would like to walk more, but said the nurses were too busy and found it quicker to put her on the commode than

let her walk to the bathroom. Informants generally did not question why the nurses were so rushed, accepting it as a way of life and accommodating the nurses as much as possible.

Nursing practices in the five homes were observed to be very similar. The mornings were fairly chaotic as nurses endeavoured to complete the bulk of their work by lunchtime, sometimes with too few staff to enable them to carry it out at a more reasonable pace. A task-oriented approach that promoted dependency and made little allowance for variations in residents' mood or preferences was usual.

A common complaint from informants was that the nurses did not talk to them enough. This fact was often attributed to them being too busy. In some cases, however, it was perceived that the nurses had other more interesting things to talk about between themselves:

> "I would stop them talking about their business while they're attending to a patient, but they will talk about what they're decorating at home. They should pay attention to the patient telling them what to do."

At times, it appeared to the informants that the nurses were reluctant to engage in any form of conversation, as one resident commented:

> "They'll come in and ask for something and they've shot out as quick as a gun - they don't want to spend any more time with you than possible."

Informants were conscious that conversation was not as easy with the younger members of staff as with the more mature ones. This was a common problem given the large numbers of young nursing staff found in the sample homes, and presented obvious frustration to those whose only source of conversation was with the nurses. One 65 year-old lady who was virtually confined to her single, second storey room, and had only been out once in the seven years she had resided in the home, commented:

> "The young nurses aren't used to speaking to older people. They are in and out very quickly. If I were to speak to the younger ones about the old days, they'd think I was going up the wall."

Communication difficulties were attributed to a lack of understanding on the part of the young nurses of what it was like to be old:

> "You can't talk to these young ones, because they haven't got the sense to know what they're talking about. They don't seem to realise that they'll be old themselves one day."

The months of interviewing demonstrated that residents valued the opportunity to share their experiences and life histories with an interested party. Encouraging informants to talk about their lives inevitably extended the interview process, but built up a good rapport and helped develop the trust necessary for full and frank disclosure about informants' present living arrangements. Expectations and attitudes about nursing home life were placed in a context and this furthered the understanding of the views expressed.

Many hours were spent with a 91 year old man who recalled at length his experiences of working in Peru, for which he was awarded the Order of the British Empire. He continually apologised for being so talkative and said that usually there was no one interested in listening to his life history.

Many hours were also spent listening to the European travels and pouring over the old

photographs of a 94 year old lady who had spent some years in operetta. She longed for companionship and complained of the "empty, complete and utter silence" that she experienced. Sadly she reflected:

> "When you're older, people dismiss you and think you're a nitwit. They know nothing about your life. I've been all over the world - I've even danced with Onassis for six weeks. None of the sisters even know about my life - I've never told them and they've never asked me."

Nursing home D recognised the importance of interpersonal communication and permanently employed one of their older sisters in visiting residents for a short period each day. This person was mentioned by informants as a highly valued visitor. However, residents at this home still desired that the nurses should spend more time talking to them.

Some of the root causes of nurse/patient communication problems were highlighted during a staff training programme for assistant nurses that had recently commenced at nursing home D. As an exercise, staff were instructed to talk to a resident and find out about some aspect of that person's life history. In the group discussion the

following week, staff related the difficulties this task had presented them with. Some admitted that they did not know how to initiate conversation without also having a caring task to perform.

Lack of information was sometimes a problem for residents. A few informants commented that they were never told when there had been a death in the home. One of the informants was suddenly taken ill during lunch in the dining room and died shortly afterwards. His room mate was informed of the death, but as it became apparent, nobody else knew, even several days later. Residents were left to imagine what the outcome had been.

Other incidents where communication was considered to be unsatisfactory by informants included unannounced visits from doctors, and the lack of warning given before rooms were rearranged or decorated.

A further common perception that emerged from the descriptions was that the nurses were not always as prompt in attending to residents' needs as they

could have been. This concern was particularly related to toilet needs, as explained by the following lady:

> "They're a long time coming when you want them - that's their only failing. I wet myself yesterday they took so long - it makes me ashamed."

Informants who infrequently rang their bells, felt that at the very least nurses should respond speedily to their toilet needs; this was not always observed to be the case. On one occasion, having completed a lengthy interview with one lady, her urgent request for a commode was conveyed to a nurse. It was met with the reply "Oh, she'll be alright for a little while yet."

There were other examples where informants described insensitive behaviour on the part of the nurses. One lady objected to being a source of amusement to nurses when being bathed and commented: "I don't enjoy my bath - they laugh at me - it's embarassing."

During the periods of observation further examples of insensitive behaviour were documented. During one interview with a female resident who shared a bedroom, two nurses entered and proceeded to

undress and bath the other resident. Conversation became difficult above the screams and shouts of objection coming from the bathroom. It was little more than five minutes before the task was complete and the now dejected resident sat back in her chair, dressed and told "now, that's better isn't it". One nurse commented "she doesn't like her bath much". This was hardly surprising for there had been no warning or choice about what was going to happen to the resident; she was handled roughly and no attempts were made to converse with her, calm her down or preserve her dignity. The speed at which the bathing took place left the author and no doubt the recipient, breathless. Even the resident being interviewed commented "that's the quickest I've ever known them bath her".

This action prompted the informant to describe other incidents where she perceived the nurses had acted insensitively:

> "I've had two people die on me since I've been in here. When they were short of staff, matron asked me to watch Betty and when her last breath goes, to ring the bell. Well, I was trying to watch her and watch the telly. So when she'd gone, I rang the bell. My daughter was disgusted that I'd been asked to watch for someone to die."

The occurence of just one incident where staff were perceived to have acted badly was remembered by residents in vivid detail and dwelt upon. One resident had recently lost her husband with whom she had shared a room in the home for four years. Emotionally, she recalled an incident that occured when he was dying:

> "When my husband was dying, I said put his chair near me. After lunch, he slipped off the chair onto the floor. I rang and the nurse came and I asked if she would get my husband back to bed. She wouldn't and said nothing was wrong with him. When I said I'd have him removed from here, she put him on the bed. That's the only thing that upset me. Matron was away at the time - I told her about what happened and they've been very nice to me since."

Through their descriptions, the informants demonstrated the impact that nurses' attitudes had on their quality of life and provide further indicators of the meaning of quality of care from the consumer's perspective.

As well as the positive comments about nurses' qualities, informants conveyed many specific examples of poor attitudes and negative qualities. Because of this, they perceived many of their interactions with nurses to be upsetting and unsatisfactory. Overall, informants were not

reluctant to criticise their carers, a feature commonly encountered in other research and satisfaction surveys. The data were rich and revealing in this regard, attributed to the in-depth and unstructured nature of the interviews.

The additional qualities that informants would like to see in their nurses were clearly conveyed (Table 10). Namely, they wanted them to be more attentive to their needs and quicker to respond; to take more time and care in their tasks; to be able and willing to talk, and to respect their privacy more. In summary, informants would like to have seen more professional bevaviour and practices from the nurses.

Technical care

The proportion of the resident's day during which nursing care was actually received appeared to be relatively small, the majority of caring activities being concentrated in the early morning and evening. The main physical tasks described by informants included dressing and undressing, washing, bathing and toileting. The performance of

these tasks constituted the most significant periods of contact between the resident and nursing staff.

As informants considered the main purpose of their being in a nursing home was to receive nursing care, the skill and competence with which nurses performed their tasks was important, as the wife of a newly arrived married couple indicated:

> "He fell out of bed hitting his head on the furniture. The three night nurses came - they were frightfully good. They did it deftly, so that was the great advantage of coming here where they are fully staffed and trained nurses."

There were other examples of high standards of care and general satisfaction was expressed with most of the basic physical care. Contrasting with these however, were examples of care that was much inferior in quality.

During his second interview, an 85 year old man, living in a small basement room, revealed that an accident had occured a few days previously:

> "When they put me in the bath last week, they caught me down here *(pointed to his penis)* and I had to go to hospital - it was very bad. Now the doctor is coming today to take the stitches out - nasty. They caught me on the edge of the bath when lifting me up. They weren't strong enough and don't have the know-how - you must have found that out as you've gone around. I don't say anything - I'm not too bad now. They've got no lift here - they're going to get a chair lift now. There has to be three to lift me - it was a male nurse that was with me the day I was dropped - he didn't know how to handle me. Matron was upset - someone had to take me to hospital and that's overtime. It's a pity I've got to be here in the first place."

During the week of this accident some serious deficiences in the standards of care at this home were documented in the field notes and concerns recorded that the home was heading towards a 'crisis' situation. There were many factors contributing to this and the situation existing in this home will be explored more fully in chapter 10. Poor working conditions, low pay, inadequate buildings and facilities, all contributed to low morale, a high turnover of staff, recruitment problems, proprietor burnout and ultimately a fall in nursing standards. It was not hard to see how such an accident as described above had occured.

The importance of staff training was emphasized by informants and a preference to be cared for by

cared for by qualified nurses. Informants could easily distinguish between the nursing assistants and registered nurses. They recognised that assistants were untrained and viewed them as somewhat incompetent at even incompetent. Informants also identified a difference in the quality of care provided by qualified and unqualified nurses and generally showed more respect for the Registered Nurses (see Table 11).

Table 11. Type of nurse found in nursing homes according to residents' preceptions

Type	Preparation	Skill	Reaction
Assistant	Untrained helper	Incompetent/ Somewhat competent	Insecure/ Ambivalent
R.N.	Trained	Somewhat competent/ competent	Ambivalent/ Confident
Matron	Specialist	Competent	Confident/ Respect

Age was still important, however, and doubts remained about younger qualified nurses:

> "The deputy's a young woman - well you can't be a trained matron at 23. She looks the part though doesn't she."

The younger staff were not perceived to be "real nurses", but only "assistants", or according to one informant, "scrubbers".

Specific areas of training considered necessary were identified by informants. Correct lifting was a major concern, particularly getting into and out of the bath, which could be a nightmare for some as the following examples indicate:

> "I don't like bathing very much - being pulled about and lifted up in the air and the girl doesn't know how to get me down."

> "I'm worried whether I'm going to get hurt or if the nurse is going to hurt herself - there's no one more pleased to get out of the bath than me. They've got to know the particular way to lift."

The male informant who received an injury as a result of the nurses' poor lifting techniques, recommended that they should pass a practical examination in lifting. Other suggestions included training in how to turn and how to undress residents. A 91 year old ex-matron commented about the lack of pressure area care and asserted that she would have had the nurses do more "real" nursing. One very dependant lady who suffered from multiple sclerosis commented that she found it tiring having to educate the new ones about what to do all the time. So did a 91 year-old Major, who became very upset if his daily routine was disrupted. He complained:

> "It isn't any good showing them once and thinking you've made a nurse out of them. I say `listen young lady, I can't stand on one leg and try and get hot water - I've got to have assistance'. But things don't happen as a matter of course."

Availability of carers

A common view expressed by informants from all the homes was that there was a staff shortage. Of course many of the deficiences identified in the delivery of nursing care were attributed to the lack of staff. Informants appeared resigned to the loss of weekly baths, the missed hourly turning, the hours of waiting, the absence of outings, even to the garden, and the lack of rehabilitation. Staff shortages were often perceived to be at the root of all these deficiencies.

There was also the view expressed that it was difficult to recruit qualified nurses. One informant had accurately monitored the staffing situation in her home:

> "At first there was only 16 patients - there's 24 now and they've still only got six nurses. They haven't got so many they say they have on day duty and they've only got two on night duty."

Sometimes staffing shortages had serious consequences. On the first field visit to nursing home C the door was answered by a young cook and the author was invited to wait in the hall for matron with whom an appointment had been arranged. During the long wait it became apparent that a resident was on the floor in the lounge. There were no nurses available and after some considerable effort, still no help was forthcoming. Some ten minutes later matron appeared and instructed the cook to help her lift the resident back onto a chair. It was subsequently discovered that it was the cook's first day and that there was only one assistant nurse on duty that morning apart from the matron. Clearly, on her first day the cook was expected to double up as a nurse, despite her lack of induction to the home and her obvious ignorance of nursing practice.

Continuity of care

Frequent turnover of nursing staff was perceived to occur in all the homes, with unsettling consequences. Informants indicated that they

became attached to certain nurses and were saddened when they left:

> "We've lost several lately - I get upset about that. Of course I don't know the girls so well now, You've got to get used to the new ones."

New nurses meant having to learn new names and invariably, changes to routine. Of course, the longer the resident had been in the home, the more changes they observed. One commented that in her four years, only two of the original nurses remained and in her view, they kept the place going. Another lady who had been a resident for nine years was perplexed by the appearance of a male nurse:

> "It doesn't seen to be the same as it used to be. A man gave me my breakfast yesterday - I'm not used to it. They never had male nurses - I think one put me to bed - it's all muddly to me. They're all new - I don't know some of them."

CHAPTER 8

THE NURSING HOME EXPERIENCE: CONSUMERS' PERSPECTIVES

FINDINGS (2)

SOCIAL ASPECTS OF CARE

A third broad area that emerged from the interview material related to how residents spent their time each day and conveys their feelings about the value of what they do. Three main sub-groups were identified in this category: ways of passing the time, types of social interaction, and involvement with communal activities (see Table 12).

Passing the time

As many well-known studies have documented, the lifestyle of elderly people in residential care is largely one of inactivity. The findings of this study concur with these findings. Informants explained that when they were not sleeping, dozing or just 'sitting', the activities that occupied their days were mainly passive. Thinking about their past life was a common occupation and

a perfectly legitimate one in the eyes of one lady who commented that it was "part of the end of it". Thinking was one of the only occupations that a blind resident considered she had left open to her:

> "Like the old lady said - I sit and think and think and think. I think about my life, my brothers and father and mother, where I lived and the house."

Table 12. In-depth analysis of: social aspects of care

PASSING THE TIME	Individual activities	- Sleeping - Sitting - Thinking - T.V./ - Radio - Reading - Knitting - Letter writing - Gardening - Painting - Walking in garden
SOCIAL INTERACTION	Visitors	- Family - Friends
	Residents	- Confused - Lucid
	Community	- Church - Shops - Post Office
COMMUNAL ACTIVITIES	Outings Occupational therapy Concerts/recitals	

Expressions of frustration about the lack of things to do and complaints of boredom were all too common. One long-standing resident summarised her day as follows:

> "Everyday's the same as the next. A typical day is a boring day. Just reading, going down to meals and coming back. Having a rest on my bed - pick up a book and read a bit more."

Even though most informants had struggled with the activities of daily living before they entered care, being plunged into complete inactivity and dependence was difficult to bear and engendered feelings of uselessness. A new female resident commented:

> "Unfortunately it's more sit around than anything else - don't do anything you see - I've always had something to do. They think I'm too old, because I'm past seventy. They think that you've no interest in life, nothing to look forward to. It seems that your life has - well - not exactly ended, but there's nothing more to interest you. That's how it strikes me."

It was also common for informants to complain that the day was long and that inactivity made them tired:

> "I find my day very long, which is a thing I've never done in my life. I've never known a day hang so. I can't read - I do have the big print books, but I can't use my hands. I can't stand. I used to have some good days, but I think that now, being able to do nothing, I do find the time hangs and it shouldn't."

One quite mobile and very articulate informant considered that there were things she could usefully do, such as answering the phone. The lifelong interest of another informant was cookery and she said she would like to see how the kitchen was organised. Other activities in which some informants would like to have engaged included cooking and ironing; one resident commented that the ironing came back still creased after it had been done. There were only a few examples of residents' involvement in their homes' daily operations. In one home a resident folded serviettes and in another a resident was observed dusting and trimming the flowers.

The periods of observation confirmed that watching the television was a universal pastime. The comments of many of the informants suggested that the television was a source of companionship and comfort to them. One described it as her family. In the majority of cases informants did not appear to be particularly discriminating in their viewing, the television being switched on for most of the day. However, preferences were expressed for particular programmes such as sport; snooker,

cricket and bowls being the favourites. Through this media, contact was maintained to a certain extent with the outside world. Watching the news was also popular, even though they thought it was "terrible". Most were conversant about the ongoing events in a plane hijacking that had occured that week.

Listening to the radio was not a common occupation. This was however, a treasured item for two blind informants, one of whom commented that without his radio he would "go up the pole". For another male informant, the radio kept him company during his many sleepless nights; something he was not allowed to have in hospital.

Reading books and newspapers was another important and enjoyable means of occupying time. The volunteer mobile lending library was highly valued and residents looked forward to the weekly visits where this service was provided. Those with failing eyesight were particularly grateful for the large print books and the talking books from the blind association. Newspapers were not

provided in all the homes and informants commented that they would like them to be.

The descriptions provided some exceptional examples of how a minority had made their lives more interesting. One very physically dependent lady, in the advanced stages of multiple sclerosis, considered that her day was never boring. Every day she typed letters to her friends and family using just one finger and searched the papers for articles of interest to send them. In addition, she was researching her family tree. Another, more physically able informant, spent her days working on a small patch of garden the nursing home had allocated to her. Her numerous other interests included ornothology and rug-making. These sort of activities were, however, usually out of the question. Even simple activities such as knitting, sewing, reading or writing letters had become impossible because of increasing physical disabilities, and a large gap was left in the residents' lives which had not been filled by anything else. Regular help with reading and writing letters, or turning the pages of a book, would have been welcomed by a number of

informants, but they did not like to trouble the nurses.

Social interaction

There was little evidence that informants had formed any significant relationships with other residents. With the exception of one or two informants who sometimes visited particular residents, they generally preferred their own company and kept to themselves. Obvervations of day rooms and mealtimes confirmed this view, where conversation was superficial or non-existent. One lady who was anxious to return home commented:

> "They don't seem to want to know you - everybody's interested in themselves. I never made any real friends with the patients."

Much of the interaction that occured between residents was said to be instigated by the nurses. Informants often commented that they felt pressurised into joining others for meals or to sit in the day room, when they would have preferred otherwise. This was true for one informant who, in spite of the efforts of the

nurses, preferred to remain aloof from the other residents:

> "Yesterday it was someone's hundredth birthday party and people thought I should go downstairs for the party. But I thought it would be wrong because I wouldn't enjoy it and secondly, it would be wrong to go just for a party when I wouldn't normally go down. It would be better not to disturb their rhythmn."

A commonly held view was that communication with other residents was either too trivial to make it worthwhile, or that it was very difficult because of the various combinations of physical disabilities, as an informant suffering from Parkinson's disease pointed out:

> "The nurses have it fixed in their mind that I must go down to day room for coffee every morning because it's good to get me out to see and get to know other people. Well I understand all that...but you know, it isn't a prison and if I don't feel like going I won't be made to go. You're obliged to of course, but not made to go. Well I see the funny side of it - we all sit there - some of us can't see or hear or talk. How we can get to know one another I don't know. I'd rather stay here and listen to my radio."

The physical structure of nursing home C made it difficult for residents to meet and informants pointed out that it was rare for them to leave their rooms.

The perceptions of what constituted a friendship sometimes differed between residents. A very sick and totally deaf man referred to his room mate as a great friend. However, the room mate confided that this was not the case; as far as he was concerned they had nothing in common. The nurses were also under the impression that because the men shared a room, they would be friends. In only one home was any mutual expression of friendship observed between residents; four of the longest standing residents regularly met for coffee and afternoon tea in the lounge and individually said that they enjoyed each others company.

Indifference towards other residents was common, but sometimes feelings of impatience and intolerance were also conveyed:

> "Some of the people here have got nothing to interest them - they say 'my life is my television' - heaven forbid. They don't move out of their chairs and become more and more like vegetables."

The presence of confused residents in the home was generally accepted by informants, but a willingness to mix with them was not apparent.

There was a reluctance to sit in the lounge with confused residents and objections were voiced about having to eat meals with them. Where there was only one lounge, informants expressed a preference for remaining in their own rooms. One informant feared that if she mixed with confused residents, she might become that way herself. The informants found it particularly disruptive if confused residents became noisy or aggressive. One very sick informant commented that she had not slept for two weeks since the home had admitted a "screamer". Another lady related with great hilarity the occasion when she was awoken in the night to find that a confused male resident had entered her room, taken his pyjama trousers off, and was trying to get into her bed. She commented that it was not so amusing at the time.

Informants developed strategies for dealing with the confused residents. One of the few mobile residents at nursing home C was a confused woman who spent her afternoons knocking on the doors of other residents on her floor. One of the strategies mentioned by residents for dealing with

her tireless questions about whether tea had arrived, included pretending to be asleep.

Clearly, informants valued the interactions they had with their families and friends the most and looked forward to their visits. The location of the nursing home had an effect on the regularity with which some informants received visitors. Two of the homes were virtually inaccessible by public transport and therefore presented problems for some of the visitors. One male resident lived in a home some distance away from where he used to live and he was so determined to continue seeing an old lady friend, that he paid for her one and a half hour taxi journey to come and see him every few weeks.

Informants did not give any indication that their relatives were in any way involved in nursing home life, apart from taking home the occasional bag of laundry. Relatives and friends were, however, the only means that residents had of obtaining an outing from the home, although less than half of those interviewed actually reported being taken out. Sometimes this was just a local excursion in

the wheelchair, a ride in the car, or less often, a day at their family's home. Mostly, however, outings were not a regular occurance. Few informants were able to get out of the nursing home without assistance.

After years of virtual confinement to one room the desire to go out diminished. One male informant considered that his disabilities were too bad for anybody other than his family or friends to see. Others worried that their incontinence would cause too much embarassment or that they would be unsteady on their feet. Some felt that it would be too much trouble, as one lady who had lived in the same small bedroom for nine years explained:

> "Oh, I don't want to go out. I've got arthritis and no shoes - I can't explain. You see when you can't do anything yourself, you have to call the nurse to go to the toilet. It takes two to lift me - so it's all - you know - I can't be bothered."

There were also those who longed for an opportunity to go out, even just to sit in the garden in the summer, go shopping, attend a church service, visit a relative, or be taken for a car ride around the city they lived in, but had not seen for years. Whilst some informants said they

would appreciate the home taking them on an outing occasionally, this generally did not mean an organised group outing, the prospect of which generated little enthusiasm.

Communal activities

Any activities that were organised by the homes, tended to be communal and occured on special occasions, rather than on a regular basis. Concerts around Christmas time, a visit to a pantomime or a hundredth birthday party were some examples of the events mentioned by residents. One informant commented that she had enjoyed the outing to matron's new nursing home and the strawberry tea afterwards at her house. During a visit to nursing home D there was an organ recital in the lounge and residents were being encouraged to attend. One informant commented that she did not wish to attend since she preferred other kinds of music. She explained that she would be the first one down if a big brass band was to come and play on the lawn.

The other social event mentioned was occupational therapy. This was provided on a regular basis in just one of the homes and was viewed with mixed feelings. It was described as "great fun" or a source of anxiety, as the following two comments illustrate:

> "Once a week I have occupational therapy - nobody knows what a tremendous effort it is, but I show willing. I generally think it's good, but not for me at the moment - I think I'm beyond that. I think it's wrong to pressurise people, but I haven't got enough energy to do anything about it."

> "I went to occupational therapy once, but if I bend down I fall and that only worries everybody, so I didn't go again. They thought I was being awkward, but I'm not."

INSTITUTIONAL ENVIRONMEMT

Another major focus of the informants descriptions of nursing home life was the institutional environment. Views and sources of satisfaction were expressed with many dimensions of the environment in which care was delivered, including the physical environment, the physical amenities, services provided and the institutional regime (see Table 13).

Table 13. In-depth analysis of institutional care

SERVICES PROVIDED	meals	- quality - quantity - temperature - presentation - choice
	hairdressing	
	chiropody	
	physiotherapy	
	dental care	
	medical care	
PHYSICAL ENVIRONMENT	gardens	
	bedroom	- single - shared
	furnishings	
	decor	
	atmosphere	- peaceful - noisy - homely
	safety	
	cleanliness	
PHYSICAL AMENITIES	lounge	
	dining room	
	lift	
	nursing aids	
INSTITUTIONAL REGIME	routine	- mealtimes - bedtime - rising time - visiting hours
	own possessions	

Services provided

The standard of the meals provided was a major concern and at only one home did the informants offer unqualified praise of the food. The

presentation, quality, quantity and temperature of meals were all considered to be important. There was general agreement that the quantity of food was adequate, although some considered that they were given too much. A choice of food and also where it was served contributed to informants' levels of satisfaction with this service. Only two out of the five homes operated a choice of menu and one of these distributed a menu every day of the week from which residents could make a choice. At other homes, a number of informants were critical of the lack of choice of food:

> "There's no choice - you have what's given to you and it's all dished up on the plate - you get used to it though. They've got a cook and you just have to see what she decides - it's nothing to do with the patients."

If dissatisfied, it was rare for informants to pusue their complaints and a sense of powerlessness was conveyed. Informants often concluded that there were insurmountable difficulties involved in catering for individual tastes. Furthermore, there was an acceptance that cold food and drink was the price that residents had to pay for having it brought to their rooms. Strong tea, soggy toast, frozen or undercooked

vegetables, and Christmas pudding that "couldn't be eaten with a knife and fork", were just some of the more specific complaints about the standard of cooking. On one occasion a resident decided it was time she had what she wanted:

> "I got fed up of soup for supper, so I sent it back last night and said I'd have boiled egg and bread and butter and I enjoyed that."

Where provided, hairdressing was a a particularly valued service. Informants mentioned that they received this service every one or two weeks and that it was something to look forward to. Some informants did not have a regular hairdresser and explained that they usually had to rely on one of the nurses to wash, cut or set their hair. Again, it appeared that shortage of time meant that this was not such a regular occurance.

Physiotherapy and chiropody were services that informants valued where they were provided. The chance to receive physiotherapy provided hope for improvement and ultimately a possibility of going home. Generally, however, informants claimed that it was really left up to them to improve the functioning of limbs weakened by a stroke or

joints crippled with arthritis. One male resident said that he had to ring his bell every afternoon to get the nurses help him stand up. He was concerned that because the home did not provide physiotherapy, his progress was not as good as it could be. Treatment at the local hospital as a day patient was something that in his view should be arranged by the home.

From the informants' descriptions, dental care was was an infrequent and much needed service. Several complained of their poorly fitting dentures and pointed out the problems they encountered with eating.

Visits from a general practitioner (G.P.) were described by informants as an infrequent and somewhat hurried affair. It was generally the home that organised for a G.P. to visit when necessary. One informant explained that she could have a visit from her own G.P., but it was such a troublesome procedure that she no longer bothered. She would have preferred his visits as she felt he had a greater understanding of her case.

Physical environment

One of the most dominant factors influencing the quality of nursing home life appeared to be the physical environment of the nursing home. Gardens were specifically mentioned by half the sample. Indeed two of the homes had particularly magnificant grounds and much appreciation was expressed for them. All the interviews with one male resident took place in the nursing home's grounds, where he would sit in a wheelchair on his own every day. He commented:

> "When I come out here I feel like Lord of the manor. I think all this is mine. I don't understand that on such a lovely afternoon like this nobody has come out. They should encourage them to come out I think."

Great importance was attached to having a room of their own and those informants who were sharing clearly indicated that they would prefer a single room. Residents wanted to have a place to retreat to that offered them privacy and a place to entertain their visitors. Small rooms were a disincentive to bringing in a worthwhile amount of personal furniture and limited informants to just very small items. An attachment to their personal bedroom was generally conveyed by informants; this

was especially true for those who had surrounded themselves with items of their own. Informants expressed a desire not to be moved to another room. A blind informant complained that he had been moved several times and each time this involved him having to get used to his room all over again.

At nursing home C, the matron commented that the room of one of the informants was on the small side, but that the resident did not seem to mind. The room was in the basement and well below regulation size. There was no carpet, the window was sealed up and there was only room for a visitor to sit on the bed. The room was equipped with an old hospital bed, a vinyl covered geriatric chair and a locker. The inhabitant of this room was uncomplaining and said that his present position compared favourably to his recent stay in hospital. A more pressing concern was that he received the necessary attention, which he thought was more likely from his room as it was opposite the kitchen from where he could easily be heard when calling out for a nurse. This resident was subsequently delighted when he was moved to a

larger room on the first floor after a friend of his complained to matron. There was an immediate and significant impact on his general well-being and he became more cheerful and positive about his progress.

Financial concerns were the only reason why informants expressed a preference for shared rooms. For those residents funded by supplementary benefit, the allocated limit was only sufficient to pay for a shared room, unless someone topped up the fees:

> "I don't want a room by myself. You see if I had a single room, the rent would go up and my daughter would have to find more money."

One of these informants complained bitterly that confused people were always put in with her and that she was tiring of it. Only one informant, the 91 year old First World War first aid nurse did not object to sharing. She explained that someone had to watch out for the three confused ladies with whom she shared:

> "I don't mind sharing. Everybody's got to get old - you've just got to feel sorry for the old things and do what you can to help them."

The furnishings and decor were aspects of the physical environment that were also commented upon. The "gastly" colour of a counterpane, peeling wallpaper, a broken towel rail and a threadbare carpet were all things that concerned informants who spent the best part of their day in one room. One lady commented that her visitors would think she "put up with anything". Another informant was ashamed of her old commode and said that she would buy herself a new one if she won the bingo. This lady also considered that she might have had some say in the colour of a new carpet that was recently laid in her room. The lack of storage space was also a problem and the inadequate size of wardrobes was commented upon.

Sources of satisfaction with the environment of care included the general pleasantness of the atmosphere, and the peacefulness. There was a desire expressed to have quiet and tranquility. The ringing of call bells, day and night, was a particularly unwelcome noise. In one home, after the complaints of one informant the bells were switched off for a few hours rest each night. Cleanliness was often mentioned as an important

quality and most informants appeared satisfied with standards in this regard.

Only one male informant discussed the important of fire precautions. He said that he had expressed his concerns about the apparent lack of any fire drill to the inspectors that visited the home when nursing home B was the subject of an Appeals Tribunal. He was happy to report that since the Tribunal, the home had installed fire detectors and procedures and he now felt much safer.

Physical amenities

The choice of sitting in a lounge, or eating in the dining room where these facilities were provided was appreciated; it gave informants a change of scenery and the opportunity of talking if so desired. At nursing home C there was no lounge or dining room. This was considered to be a deficiency and informants comments highlighted the isolation it created:

> "What I miss is a day room where everybody can collect together for lunch, tea, whenever they want. Here, you're in your room all the time - there's nowhere to go."

The absence of a lift of any kind compounded residents feelings of isolation in this five-storey home. Being lifted up and downstairs in a chair, even one floor to a bathroom, was a worrying experience. Many commented that they felt so unsafe, they would prefer not to go out at all. Concerns were also expressed about the possible injuries to nurses, who indeed tried to make life easier for themselves, as one informant pointed out:

> "They used to lift me and take me into the bathroom, but they don't now. They can't lift me - it takes too long. I'm washed down every morning - I never go to the bathroom now. If I do the other one I use the commode."

Informants identified and commented upon the lack of nursing aids in nursing home C. A preference was expressed for the use of a hoist to get them into the bath, but none were provided at this home. Consequently, bathing was not a particularly pleasurable experience.

Institutional regime

Informants' lives were organised around a daily routine, marked by rising in the morning, meal

times, morning and afternoon tea and going to bed. This was a typical day described by one informant:

> "I'm an early riser - usually by 8 O'clock. They do your bed and bits of cleaning. I can have breakfast up here or downstairs. Then there's the washing, but you don't do your own as nothing is dirty. Lunch is at one o'clock. After lunch you look at your telly. There's two lounges and the other old people tell you what they've been up to. At the end of the afternoon I sometimes have a sleep on the bed - I never did before. We have a cup of tea and cake at 3.30 and nothing more till supper at 6 O'clock. After tea you can go to bed if it's dark, or look at the telly. I go to bed at 9 O'clock. Someone comes here every Tuesday to do my hair. I can't tell you really, you've just got to experience it - you just have to go along with the routine."

The routine was sometimes found to be unnecessarily restrictive and was likened to being in a prison or being caged. It was often asserted that "you have to do as you're told." One rather frail resident talked about how he had enjoyed going for walks near the home, but added that the nurses now kept an eye on him because he had gone out one day without telling them and they thought he had "escaped."

The nursing home routine was not always responsive to individuals' needs. Some informants felt that they were forced to retire to bed too early and

for others it was too late, and the same was true for rising time in the mornings. Particular aspects of the routine, such as the afternoon rest, were new practices for informants, but there was a perceived pressure to conform and informants soon acquiesced. Mealtimes also changed habits of a lifetime, but informants commented that they did not always feel like eating at the regular meal times.

Despite the routine, sometimes a degree of flexibility was possible. Visitors could generally arrive when they wanted to and this was important to residents. Favourably mentioned also was that in two of the homes, the front door was never locked in the day, so their visitors could enter without ringing the bell. A long-standing resident of one home concluded from her friends comments about other homes, that she had a lot of freedom where she was. This view of freedom, however, related to being able to move about the home and sit upstairs in her room or in the lounge.

The presence of informants' personal belongings in their rooms also reflected the type of regime adopted by the nursing home. One occasionally confused informant explained her enthusiasm for windmills and derived great pleasure from the number of models and pictures of windmills that she was able to display in her room. Old photographs and antiques displayed in rooms were often the centre of discussion and prompted informants to recall their past. Informants without such personal possessions commented that they did not realise that it would be allowed and others considered that their rooms were too small to make the display of anything satisfactory.

FINANCIAL ASPECTS OF CARE

Paying for care was identified as a major source of worry by informants. Concerns specifically related to three main areas; the cost of care, the administration of affairs and financial assets (See Table 14).

Table 14. In-depth analysis of category: financial aspects of care

COST OF CARE	level of fees information increases value for money
ADMINISTRATION OF AFFAIRS	family solicitor self nursing home
FINANCIAL ASSETS	personal expenditure supplementary benefit personal allowance spend down

Cost of care

Informants were generally of the opinion that the fees were expensive and occasionally ventured to suggest that perhaps they should get more of what they wanted for the money.

There was a certain amount of ignorance about the level of fees charged and informants indicated that they would like more information in this regard. A new resident, who had been quite sick on his admission commented:

> "I haven't really gone into the cost of all this yet. I've no idea what it will cost. I shall ask the doctor about it when he comes. I wasn't well enough last week."

Informants found it particularly distressing if they could not anticipate when the fees were going to be increased.

Administration of affairs

To retain control over the handling of their financial affairs was a source of great satisfaction to informants. Despite their disabilities and increasing frailty some informants confirmed that this had been possible. Where this responsibility was relinquished to a member of the family, or in a few cases to a solicitor, informants indicated that they were satisfied not to have the worry of handling their financial affairs, with the exception of a few who wished they had more control. It was apparent that those who were still in control of their finances were more knowledgeable about the level of fees in the home than those who had relinquished control.

Financial assets

Although informants were reluctant to talk specifically about their current finances,

concerns were expressed about how savings would last out. In spite of careful financial planning, the prospect of `spend down' was a worry to those whose accumulated wealth had rapidly diminished with years of nursing home care and they were fearful of even further price rises :

> "Three years ago it cost £280 and now it's £350. I can't go out and earn any more. My life's earnings have just been halved with inflation. How I've found the money, goodness knows. I've just had to sell my Cadbury Schweppes shares. I'm not down to the DHSS level yet, but I don't know what's going to happen to me. I could go into hospital and end my days in a quiet corner if my money ran out."

Informants concerned about their money running out were aware of supplementary benefit funding, but it was not a very appealing prospect and was viewed more as a last resort that would involve a lengthy process:

> "You hope to be able to stay till your money runs out. You can get some help, but you've got to know about it and who to apply to and so on."

The ability to live adequately on the savings at their disposal appeared to be an important part of maintaining a sense of independence in old age.

Although informants commented that there was little to spend their money on, they nevertheless

found it embarrassing and inconvenient to have to ask the matron for money every time it was required, e.g. for the church collection and hairdressing. A few informants mentioned that their fees were paid by supplementary benefit and three of these commented that they did not receive their personal allowance. It was quite likely that price rises accounted for the disappearance of personal allowances, but this was obviously not explained. A blind informant was convinced that the home owed him "pounds and pounds" and that somebody must be spending all his money.

ADJUSTMENT TO CARE

This dimension of the nursing home experiences consisted of the spontaneous reflections that informants made about the situation in which they found themselves; how they had settled in; their overall evaluation of nursing home life and their future care plans, hopes and aspirations (Table 15).

Table 15. In-depth analysis of adjustment to care

SETTLING IN	Settled	- Contended - Relief
	Mixed feelings	- No choice
	Unsettled	- Regret - Desire to leave
PLACE TO LIVE	Refuge	- From society
	A home	- Like home - Independence from family - Not the same as home
	Place to die	
THE FUTURE	Plans	- Stay till end - Residential home - Own home
	Prospects	- Growing old/ dying

Settling in

There was a mixture of emptyness, resignation, sorrow, thankfulness and contentment in the informants' descriptions. It was unusual for informants to unreservedly conclude that they had completely settled in at their nursing homes. The feelings fluctuated between regret at having left home on the one hand and relief that they were better out of it on the other. For some there was no longer a choice about staying as their homes

were gone and there was nowhere else to go. It was not uncommon for informants to express contentment with their situation whilst also asserting that they could never be as happy as they were in their own homes. Informants frequently commented that they saw no point in being miserable and that "you may as well make the best of it."

When contentment was expressed with life experiences as a whole, informants' appeared more satisfied with their present situation:

> "I'm very happy with my life. My husband and I were very content with each other. My daughter-in-law does all the washing and my son looks after everything. I never get bored. I thank the Lord for what I've got."

The nursing home as a place to live

A striking feature in the informants' descriptions was that they appreciated the reality and finality of their situation. It was commonly acknowledged that they had come to a nursing home to end their days.

The nursing home provided a welcome refuge from the outside world for some. One informant who had

left her sheltered housing after a series of unfortunate experiences commented:

> "I've got no one to upset me. I think I'm hiding away from the world and humans, where I'm secure. The outer world doesn't interest me any more - only as a reading material. I think it's a wonderful way to end your life, away from the humans who can be so cruel. The sisters here are very kind - I haven't been hurt by anyone. The lack of companionship is a little price to pay for the tranquility and peace of mind - you've got nobody to hurt you. I don't want possessions, only tranquility."

Despite the lack of independence and freedom experienced, living in a nursing home was a more acceptable solution to informants than moving in with their families and in that sense did offer a degree of independence.

Looking to the future

Informants recognised that nursing home care represented the final move for them. Talk of leaving, going home or moving elsewhere was rare. Only five out of the sample rejected the prospect of remaining in a nursing home. Two of these had been rehabilitated and were ready to return home. Another two were still very dependant and unlikely to manage at home, but were unable to accept a

future in care. The belief that they would soon return home was the only ray of hope for these residents. The fifth informant thought that he was too independent for a nursing home and wanted to go into a residential home nearer his friends.

Relationships with children and grandchildren made life worth living for many informants, but the future was not always viewed optimistically. One informant said she hated growing old and described it as "torture" that there was nothing more to look forward to. Some hoped that they would not last too long and were obviously contemplating the prospect of dying:

> "I wish there was a nice easy way to end your days -euthanasia - although I couldn't do it, because I was taught that no man knows his hour".

CHAPTER 9

SUBSTANTIVE FINDINGS: KEY INDICATORS OF QUALITY OF CARE

From the wide range of experiences and views analysed in the previous chapter, it is possible to identify the key indicators of quality of care from the consumers' perspective. In terms of the objectives of the study these were:

1. Important dimensions of nursing home life,
2. Expectations of nursing home care,
3. Expressed preferences,
4. Aspirations for improvement,
5. Sources of dissatisfaction.

Whilst it would be untrue to say that informants were completely dissatisfied with the quality of care and the quality of their life, unreserved expressions of satisfaction were uncommon. Inevitably the intensity of the informants' concerns varied, indicating that the elderly are not an homogenous group. However, the areas identified in this chapter as key indicators of quality were those that demonstrated the most stability in the analysis, i.e. they were areas which consistently emerged in the interviews and

were explored in the fullest possible sense. Informants from every nursing home, whatever their state of physical or mental health, conveyed feelings of boredom, loneliness, diminished self-worth, dependency and powerlessness. These views are similar to those expressed in a consumer study of institutional life in six Local Authority homes which concluded that the views of residents:

> "convey a complex mixture of feelings: gratitude, resentment, resignation, powerlessness, acceptance, dependence and illustrate that the quality of life experienced by most residents left much to be desired." (Wilkin and Hughes, 1987)

1. IMPORTANT DIMENSIONS OF NURSING HOME LIFE

The most highly valued dimensions of nursing home life were informants' relationships with family, relationships with nursing staff, the environment of the home, personal and therapeutic services and the ability to exercise control.

Family and friends

Positive, close and stable family and social relations were a major determinant of informants' valuations of the quality of life, a finding that

is consistent with other studies (Najman and Levine, 1981; Greene and Monahan, 1982). Most informants stated that they had "wonderful" children and even more remarkable grandchildren and generally displayed great pride when talking about them. However, the nursing home setting was not the ideal place for normal socialising and interaction between the family and resident. The activities of any young grandchildren were understandably restricted and the home's routine did not make it easy for family members to prolong a visit.

Resident-staff relationships

Although it was rare for informants to form close associations with nursing staff, the highest importance was attached by informants to the quality of their interactions with the nursing staff. The attitudes of nursing staff were very relevant to both the quality of care and the quality of life experienced by nursing home residents. The importance of the conduct and interaction of health professionals with patients has been alluded to in other settings as an

important source of influence on patients' satisfaction (Lochman 1983). A consumer study of geriatric patients concluded that:

> "Patients tended to lay more emphasis on the psychosocial aspects of care - that nurses had a gentle or kind manner, that they were welcoming and introduced themselves when dealing with admission." (Wright, 1988)

Hoch's study of life satisfaction in retired people supports these conclusions. When nursing interactions that demonstrated the use of an holistic approach concerned with the psychosocial needs of individuals were carried out, then depression was found to decrease and life satisfaction increased (Hoch, 1987).

Environment

The home's environment also emerged as an important dimension for residents. Gardens obviously gave considerable pleasure to sit and walk in. Even when informants no longer ventured outside, a view of the gardens was appreciated. The other valued aspect of the environment was that it was peaceful.

The personal aspects of the environment were equally of importance. It was possible to preserve a sense of dignity and personal identity by the personalisation of rooms with residents' own possessions. Photographs of the family and treasured pieces of furniture were always talking points at some stage during the interviews.

Services that helped bridge the gap between the nursing home and the community were highly valued. Hairdressing, chiropody and the mobile library were some examples cited. When physiotherapy was provided it was also highly valued. This was not however, a routine service.

2. EXPECTATIONS OF NURSING HOME CARE

Competent nursing care

Whilst there was generally a level of ignorance amongst informants about what to expect when they were first admitted to a nursing home, there was nevertheless, a certain level of expectation about what should be provided. Informants expected nurses to have the technical knowledge and skills

necessary for managing equipment, performing skilled procedures, such as physically transferring residents with limited mobility. Safe and efficient transfer of a resident from bed to chair or toilet, or chair to bath, were consistent expectations.

The need for nursing care was the major reason for residents entering a nursing home in the first place and there was consequently an expectation and preference for care to be provided by qualified nurses.

3. SOURCES OF DISSATISFACTION

Information

Lack of information was a continuing problem for informants and affected the quality of their lives in a number of ways. First, there was a dearth of information available before admission to a nursing home. Advice on many practical considerations was seemingly not available for new residents. For example, household furniture and personal effects were often disposed of before it

was realised that nursing homes permitted residents to bring in certain items. As the previous descriptions demonstrate, the quality of life was significantly reduced for those informants, who because of lack of advice and information, were left with very few of their own possessions.

Secondly, informants had little information on what to expect from nursing home life and were not prepared for the fundamental changes in routine they were immediately subjected to. Lack of such preparation for the move clearly had a bearing on the informants' adjustment to the nursing home environment.

There were other sources of dissatisfaction relating to information-giving that affected residents' lives. Ignorance of the fees charged and increases planned were a major source of worry for informants. If a third party was managing the financial affairs, communication over such matters was not generally directed to the resident. However, this did not always diminish informants' anxiety about finances.

Thirdly, the future of the nursing home and potential changes of management, proposed extensions or developments, were an obvious concern to residents. Information in this regard was gathered in a piecemeal fashion from casual comments made by staff, other residents and then often embellished by informants to give a totally inaccurate picture of the future. Informants were anxious to know the implications of nursing home changes for their lives and that this information was not forthcoming in a formal manner was a matter of concern.

A further area of the homes activities where little information was offered concerned developments with the other residents. New residents arrived, left or died with regularity, but again informants remained often partially informed about such occurences.

Information is an important aspect of residents' rights. Residents who have the information necessary to understand the environment in which they live and solve problems are better able to cooperate with nursing home staff. Higher morale,

greater life satisfaction and better adjustment are known to be the outcomes of ensuring residents' rights such as the provision of information (Institute of Medicine, 1986).

Admission experiences

Widowhood combined with the loss of home, possessions, independence and health, meant that admission to a nursing home was a stressful event. Entering a nursing home was not a discrete, time-limited event, as Chenitz (1983) pointed out, but ongoing for an indeterminate period.

The losses associated with entering care caused grief that was not necessarily overcome after an initial period of adjustment. Glaser and Strauss (1971) described this movement from one of life's resting places to another as a status passage. In the case of entry to a nursing home, it was the case that residents were often juggling several passages at the same time. These passages involved role exit which produced change in an individual's associational life, self-concept and mood. Environmental discontinuity is a major experience

for new residents (Tobin and Leiberman, 1976:219). Stein et al (1985) suggested that anxiety about placement could be significantly reduced if anticipated stresses are identified in new residents and appropriate support offered.

Chenitz concluded that the outcome of relocation, i.e. the quality of life experienced by the resident, was partially dependent on a number of factors associated with the move. Such factors included the voluntary or involuntary nature of the move, the predictability of the move and the degree of control exercised by elderly people, the extent of environmental change resulting and the physical and mental health of the individual at the time of the move.

Control and dependency

The dependent situation that informants found themselves in was a great source of dissatisfaction. Whilst informants recognised that a certain amount of dependency was unavoidable given the multiple health problems experienced, frustration was experienced when the institutional

regime or environment made it difficult to maintain personal control over even the most basic activities of daily living. Bathtimes, mealtimes, rising and bedtimes were not events over which much choice could be exercised. Even the activities of dressing or walking to the toilet unaided, were denied to residents who were too slow, as many times it was easier for staff to perform activities for residents because of time constraints. Equally demoralising was the endless waiting involved in residential living; whether it was to be fed, taken to the toilet or put to bed, this was yet another dimension of the position of enforced dependency disliked by residents. Deficiencies in a home's physical amenities such as the absence of a lounge, dining room and lift, also led to feelings of confinement and contributed to the dependency of residents.

Decisions concerning the institution's decor or furnishings were rarely made with any input from residents. The regime effectively removed from residents any decision-making responsibilities, encouraging instead a life of complete dependency. Loss of autonomy over their financial affairs

further increased the dependency of residents; either the State or relatives assuming this responsibility. It was not difficult to understand why informants no longer felt useful or why they considered their lives to be virtually over. The surrender of such personal independence on entry to an institution was documented almost three decades ago by Goffman (1961). Subsequently, this has been a recurring theme in studies of residential living in both Britain (Townsend, 1962; Clough, 1981; Willcocks et al, 1987) and the U.S.A. (Townsend, 1971; Tobin and Leibermann 1976; Vladeck, 1980).

Rehabilitation

There was also a perceived lack of rehabilitation and this resulted in either anger and frustration, loss of hope, and further exacerbated the dependent position of informants. They often attributed their loss of function to prolonged periods of inactivity. This is consistent with evidence that some functional impairments in the elderly may be a result of inactivity and disuse and that many residents would benefit from

rehabilitation exercises (Kane, 1981). This aspect of nursing home care clearly had an impact on well-being and quality of life.

Nurses' behaviour

There were many aspects of the nurses' behaviour that caused informants concern. Disappointment was expressed about the youth and inexperience of the assistant nurses and poor quality care was often attributed to these factors. That informants themselves questioned the competence of the nurses caring for them, and furthermore, considered that a special training was necessary, clearly highlights a major deficiency in the quality of nursing home care.

Insensitivity, inability to listen, poor communication and lack of interest were characteristics of a non-caring rather than a caring interaction with the residents. The willingness of nurses to spend time conversing with residents and take an interest in them as individuals, were critical prerequisites to a quality life experience.

Research conducted by Bowers (1988) into family perceptions of nursing home care recognised that the quality of life could be enhanced if nurses had biographical expertise. This required an intimate knowledge about the life of the older person and what made that person unique, including their personal preferences. Without that skill, Bowers argued that nurses could not provide preservative care (emotional or psychosocial care). The study further concluded that even good quality technical care would not be possible, as that should be performed in a way that took account of the individual's biography. There were strong indications in this study that the life-reviewing process was enjoyed by informants and found to be of value. However, there appeared to be insufficient opportunities for residents to exercise this process. The possible therapeutic effects include improvement in personal integration and therefore enhancement of the quality of life (Day, 1982; Butler, 1983).

4. EXPRESSED PREFERENCES

Self-fulfilment

Residents' wishes to be involved in normal everyday activities, such as shopping, ironing, and cooking, were clearly never divulged to the homes' management for fear of appearing to interfere. Such concerns inhibited informants freedom to comment, let alone complain about important aspects of a home's operation.

Individuality

In spite of the public life experienced in nursing homes, informants indicated a preference for their own company. There was an assumption amongst staff that it was good for the residents to mix with each other and that they should enjoy each others' company. This was not found to be the case; relationships were found to be casual and often fragile. Townsend (1962:347-349) noted that this was a feature of institutional populations, unlike relationships between neighbours or members of a family, because relationships may not last long

and cannot be based securely on the reciprocation of services. Residents constantly resisted attempts to encourage mixing and communal activities and resorted to the sanctuary of their own rooms where at least some sense of self-identity could be preserved. They did not appreciate the wearying and sometimes self-pitying discussion of ailments. This finding is supported by other research that suggests it is the self-directed activity patterns of residents and the less structured everyday interactions that form the bases for establishing social identities (Powers, 1988).

Privacy

The provision of private rooms was valued highly by informants and provided them with some degree of privacy. However residents could not be guaranteed total privacy in the management of their personal affairs and relationships. A cursory knock on residents' doors was the most to be expected before nursing staff entered. Generally, this courtesy was not extended at all.

Informants sharing rooms expressed a preference for single rooms and this finding is consistent with that from a study of local authority residential homes by Willcocks et al (1987). Informants clearly recognised that the quality of their lives was reduced by sharing a room, but they were powerless to do anything about it, often for financial reasons. Although privacy could have been enhanced in shared rooms by better organisation of space and the use of screens, no attempts were made in this direction.

5. ASPIRATIONS

Informants aspirations about the quality of care or life were of quite a basic kind; there were no great ambitions, but just some often forelorn hopes that small aspects of their lives could be improved.

Social fulfilment

Underlying much of the informants' descriptions was a desire to feel more useful to either themselves, the environment in which they lived,

or to society. Lack of a social environment severely impaired the physical and mental status of residents and hence their quality of life. Such findings come as no surprise, merely adding to those of other major works; for example, a longitudinal study that focused on vital involvement in old age observed that:

> "The ageing individual needs the satisfaction of feeling that the sensory antennae on which we all rely throughout life are doing their utmost to alert and empower the ageing body to remain an actively involved, as well as creative, agent in the world of people and materials. In itself this should be a reason not to limit old people to a peer group milieu, since ageing is a dead topic and can be lightened only by rather forced humour."
> (Erikson et al, 1986)

Erikson's study also noted that the world of elders could be vitalised when young people, or any other generation - especially children - were involved. There were few such opportunities for the informants to take advantage of in the study's homes.

Lack of contact between the homes and the local community further increased residents' sense of isolation. Whilst there were generally no restrictions on visiting, it was uncommon for visitors to be encouraged to take any part in the

home's life and provisions for them to stay the night or have a meal were unusual.

Of course it would be wrong to conclude from these findings that all residents wanted an action-packed existence with major new physical or mental challenges. Some research conducted in long-stay wards for disabled elderly people in Israel (Golander, 1987) concluded that residents could be considered to be taking a very active role in shaping their lives in the institutional setting. Survival skills included listening and observing, careful planning, avoiding unnecessary dependence, coalition forming and lowering aspirations to match diminished capabilities. Such strategies were often interpreted as passivity by observers, when in Golander's view, they reflected the dynamic role of the aged.

Whilst recognising that just `surviving' presented a full-time occupation for many residents, there was no doubt that for those few informants who managed to engage in individualised activities, pursue opportunities for meaningful social interaction and participate inside and outside the

home, social isolation was reduced and mental and physical status enhanced.

Informants' suggestions

Informants did have a number of suggestions as to how nursing home facilities could be improved. It was thought that the provision of a lounge and dining room where one was not currently provided would improve the living arrangements considerably. Likewise, it was hoped that homes without mechanical aids to help residents in and out of the bath, would eventually invest in such a device.

To summarise, the subjective well-being of residents was an important component of their evaluations of nursing home life. This included such factors as the level of satisfaction, the extent of depression or demoralisation, and absence of discomfort or pain. Well-being, and thus quality of life, was clearly affected by the quality of the nursing care provided and the way it was provided; the quality of the interaction between staff and residents; and residents'

ability to make personal choices and influence the range of choices; and the nursing home's ambience and physical and social environment.

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CHAPTER 10

REGULATORS AND PROVIDERS: POLICY AND PRACTICE

NURSES' PERCEPTIONS OF QUALITY CARE

Interviews with nursing staff and observations of nursing practice revealed a number of gaps between the ideal and actual practice and also some important differences between the perceptions of matrons/senior nurses and nursing assistants in terms of what constituted quality care. The areas most frequently mentioned by the five matrons and their senior nurses as indicators of good quality care were: physical nursing care; staffing; regime; and social nursing care. Nursing assistants, on the other hand, perceived that the physical aspects of care were the most important element of their role.

Physical nursing care

The physical nursing care included the accomplishment of basic nursing procedures such as bathing, washing, dressing, pressure area care and toileting, in an efficient and competent manner. Highly rated by matrons was that

residents should look clean and tidy, be well groomed and sweet-smelling. When asked about their duties, nursing assistants usually described their jobs as involving a series of tasks:

> "You look after them, wash them, feed them, give them two-hourly pressure care - that's why none of them have sores... You've got them hollering and shouting at you all the time, and you've got to lift them - it gets very hard."
>
> "We make sure they're clean, tidy, fed - that's all you can basically do for them. You can't make them happy every day."
>
> "The morning's just taken up by getting them up, feeding and washing them, toileting, talking - then in the afternoon it's a bit quieter and we go in the sitting room and talk."

The policy of one matron required qualified staff to be involved in the supervision of mealtimes to ensure that residents were obtaining an adequate diet.

Whilst matrons emphasised the physical aspects of nursing care, it was not always easy to see how good standards were ensured in this respect. The majority of nursing home staff were untrained and had little, if any, prior experience of nursing

home care. This finding is consistent with the observations of Willcocks et al (1987) that:

> "Most care staff approach the task of residential care from a background of common sense caring and experience practised in a domestic setting."

Also apparent was the little time available for in-service training of new staff, even in the most basic of nursing procedures such as lifting, bathing, feeding and dressing. It was common practice for new staff to learn as they worked with a longer-standing member of staff, and depending on who was available, this was not always a great success:

> "It was very confusing because I was on with an S.R.N. who had never done days before, so we didn't know what we were doing, but you've got to get on and do it - it's the best way."

Apart from the recent development of a training programme at nursing home D, the only sessions referred to by staff and matrons related to fire procedure and an occasional seminar on incontinence at the local hospital.

During the course of the research, nursing assistants were observed on their first day at work lifting heavy residents, dealing with the agitated and confused, feeding the bedridden and toileting the immobile, without any prior

instruction. One care assistant recalled the horror she had felt when asked to help a resident attach his artificial leg; she had never seen an artificial leg before and felt completely inadequate to assist with this task. Other assistants remembered how their backs had ached when they first started work, so unused were they to correct lifting techniques.

A male nursing assistant involved in lifting, along with two other assistants, a heavy and very immobile resident into the bath, described how they had dropped and injured the resident. The incident was attributed by this nurse to fatigue, lack of room to manoeuvre and incorrect lifting techniques. Subsequent discussion with the matron and her husband about this case revealed a total lack of awareness on their part of the deficiencies in the nursing abilities of their staff. The husband was unable to offer any explanations as to what could have gone wrong, commenting that lifting was really a matter of common sense and that he had never had any problems.

Matrons often prided themselves on the caring philosophy followed in their homes. The facilities were commonly described as being the resident's home and staff claimed that they treated residents as they would treat a member of their family. Clearly, there were times when it was difficult for homes to live up to their ideals. The kinship model is not easy to maintain when there are demands from the organisation and its routines (Willcocks et al, 1987).

All the homes believed that they maintained a high standard of nursing care, but there were many instances throughout the course of the study when observations revealed standards that were less then perfect. Although the level of physical care varied between homes, examples of poor care could be found in all homes. There were occasions when residents' demands for toileting were ignored and when residents were left sitting on a commode for long periods of time. Such care was confirmed as frequent practice by a number of informants. Neglect of the basic nursing care and activities of daily living such as bathing and exercise was also observed during the research and commented upon by informants; this was often

attributed to a shortage of nursing staff. In one home, shortage of staff was apparently the explanation for sedating a wandering resident and subsequently confining her to bed. Rehabilitation of residents did not appear to receive a high priority by nursing staff and was rarely mentioned in the interviews.

Social aspects of nursing care

Attention to the social aspects of care was thought by all the matrons to enhance the quality of nursing care. This was usually defined in terms of talking to the patients as much as possible. In all cases, however, this commitment was not borne out in practice. All matrons had extensive administrative responsibilities, including in the case of two matrons, responsibilities for another nursing home as well. Conversation with residents therefore tended to be limited to an occasional brief exchange and the informants comments about how infrequently they saw the matron supported these observations. Interestingly, in all cases the matrons considered that their contact with the residents was adequate. The two matrons, who had

responsibilities for another home as well, commented that the residents had become very possessive and "think that they own you". In the case of a particular resident, one matron explained how it had been necessary to make special visits to this resident to pacify her when she became distressed at the matron's move part-time to another home.

Attempts by the matrons to educate their staff about the value of social care were limited and inadequate. One matron, convinced that her staff understood the importance of social care, wrote in the notes 'take your time' when there were sufficient staff on duty. She found to her disappointment, however, that the nurses still rushed to finish their work by lunchtime. One senior nurse was concerned about the younger members of staff ability to communicate and commented:

> "Listening is the most important thing. I don't think that everybody has these skills - this is where the young need guidance. I think it depends whether they have a lot to do with grandparent."

Nursing assistants did not place such a high value on the social aspects of care. They

generally considered this care to be separate from the physical care they were providing and commented that they were too busy to spend time talking with the residents. There was a general belief amongst the nurses that it was inappropriate for staff to become too involved with the residents. Some indicated that there would be little gained from talking to the confused residents anyway. This view was also expressed by the husband of one of the matrons who declared that none of the patients were really worth talking to, as they were all mad.

There were many nursing assistants who found conversation with residents difficult. This was clearly illustrated in one of the training sessions at nursing home A, when staff discussed an exercise that had required them to obtain some life history details from a resident, without performing nursing tasks. Staff had found it difficult to go into the selected resident's room and initiate conversation; they believed that talking to residents was viewed as time-wasting and that it was not encouraged. Asking residents about their life and spending time listening were

therefore acts of communication that nurses infrequently engaged in.

Without any form of education, it was likely that the differing views of nursing assistants and matrons/senior nurses as to the value of social nursing care would continue. At nursing home D, the training programme was designed to encourage a more resident-oriented attitude in nursing assistants and develop some necessary psycho-social skills.

When nursing assistants commented that they did spend time socialising with residents, this appeared to be on a level that did not necessarily involve everyday communication and tended to focus on arranged activities:

> "We prance and dance around the lounge to music. I can't think of anything else. We have tried to help some to write letters in the past, but most here aren't capable. We have birthday parties and at Christmas they have sherry. The T.V.'s on most of the time, but only Olive watches it. Sometimes we switch it off in the afternoon and have music."

There were a number of nursing assistants who expressed a preference for the confused residents, commenting that they could "have a

laugh with them". Residents who attempted to engage staff in conversation for lengthy periods of time were not very popular and a number of strategies used to discourage this were observed, including taking a few steps backwards, unnecessary speed in the performance of tasks and reducing contact to the bare minimum. It was the view of one nursing assistant that residents paid for a private room, nursing care as prescribed by the nurses, and nothing else.

When asked what were the most important aspects of nursing home care, there were a number of standard responses:

> "To make the last few years of someone's life as happy as possible."
>
> "To provide as good quality of life as possible until the end."
>
> "In the job description it says that you should treat them as you would treat your own relatives."

In practice, it was not evident that nurses were able to apply the philosophy of care they had identified. That staff did not initiate conversation very often with residents, that they had a good laugh with the confused patients, or talked over them, or even avoided some residents

altogether, did not constitute the kind of treatment usually given to a relative. Indeed, it may even be inappropriate to expect staff to act in such a way given the kind of environment they are expected to work in.

These findings support those of Willcocks et al (1987), which conclude that the priority given to the material aspects of care forces social care into a secondary position. Clearly, the physical and domestic care modes were not neglected for social exchange with residents. Although social contact is inevitably involved in the course of engaging in physical care tasks, often the tasks were interrupted, or of such duration that residents did not have the undivided attention of staff for very long. There was little evidence to suggest that social care was a part of nursing home work, even though it was likely to be mentioned by matrons and senior staff.

Staffing

The organisation of staffing was also considered to be an important element in the achievement of quality care. Three of the matrons believed that

they selected their nurses carefully. One thought it was important to achieve a balance of mature and young staff. Preference was given to those with previous experience of nursing home care, or to those who wanted to undergo nurse training. Another matron surmised that it was a very spontaneous thing when interviewing potential candidates - they had to be suited to an informal atmosphere. Not all homes were able to be selective in their recruitment. Two nursing homes were experiencing problems with their staffing levels and turnover rate during the study. Staff and residents alike, attributed this to the poor rates of pay and the difficult working conditions. One of these homes was a five storey building with no lift or hoists and high dependency residents. The other home had a very poor reputation locally since it had been the subject of an appeal to the Registered Homes Tribunal and daytime staff were consequently difficult to hire.

Staffing levels did not appear to have improved significantly at this home since the appeal was granted, however, and no replacement had been found for the matron who was leaving during the

week that the fieldwork was completed. The matron admitted that standards were falling rapidly due to the staffing problems and she believed the signs of this were the return of a strong smell of urine in the home, low morale in the staff and disruption in daily routines. She further asserted that the situation had not been assisted by the owner admitting, against the matron's will, a doubly incontinent resident; someone who, at the time, the home was unable to cope with, either in terms of staffing or laundry resources.

Although the conditions of employment differed at each home, pay scales for care assistants were inevitably low and paid annual leave minimal. This was a constant source of concern to almost all those interviewed, as the following comments illustrate:

> "The staff are paid a pittance here."
>
> "We could do with a rise, especially help with the travelling."
>
> "If they gave us a rise and more holidays we'd stay."
>
> "I don't agree with the holidays - two weeks - that's for everybody."

It was generally agreed that the they were not rewarded adequately for the level of

responsibility assumed. The matron at nursing home B was trying to convince the owner to increase the pay of all the nursing staff, without much success. She commented that the day staff were mostly school leavers and were given far too much responsibility - more than any student nurse.

The inexperience of the staff and the demands of the job, combined with the poor rates of pay inevitably contributed to the high turnover rate. The consequences for quality of care were that the remaining staff were increasingly unable to meet all the care needs of residents and continuity of care was also affected. The turnover rate was a particular concern to residents as it obviously affected their ability to get to know and trust the nurses caring for them.

Studies conducted in the U.S.A. have revealed similar negative consequences associated with high turnover rates in nursing homes and long-term care facilities. Besides the most common effects of increased financial costs for recruitment and training, disrupted relations

among nursing personnel have been the result (Schwartz, 1974) and reduced quality of resident care (Halbur, 1986). A U.K. study conducted in a geriatric unit highlighted the physical and emotional stress resulting from high staff turnover rates (Smith, 1986).

In all homes, nursing staff were required to wear uniform. At nursing home A, the matron considered that a professional nursing image was an important indicator of quality care and that included the nurses wearing caps and aprons. Here the nurses were much more formal in their communications with the residents, each other and visitors. In contrast, at nursing home B, the matron's view differed; she concluded that uniforms helped to create a barrier between nurses and residents and that ordinary clothing would be more appropriate. However, her view did not concur with that of the owners, who wished to keep the staff in uniform.

Experiences and expectations

According to the nursing staff there were a number of factors beyond their control that

affected the quality of care. For example, a number of staff alluded to the physical environment creating an impediment to the safe and effective delivery of nursing care:

> "The stairs are terrible. If we have to bath that patient downstairs, we've got to carry her from the bedroom to the bathroom up several stairs - and she's hollering the whole time. We need stair lifts, but she (the matron) says it would cost too much. There should be showers too... she's getting a hoist in, but we've still got to carry them to the bathroom."

There were nursing assistants who felt their position was demeaning and demoralising at times. They believed that if they undertook registered nurses training, then more respect would be forthcoming. One of the nursing assistants who perceived that many residents treated them in a subservient and disrespectful fashion asserted:

> "I don't like the way they treat you like servants... they think you're a machine, a robot. They must remember that it's a different generation now and they can't carry on like they did fifty years ago when they had maids."

Lack of experience and maturity on the part of nursing assistants sometimes showed itself in unrealistic and inappropriate expectations of residents, creating conflict at times. This is

illustrated by the following comment from a nursing assistant:

> "They won't mix together - I think they should. This morning one lady got up and walked away because we sat her next to a confused lady. They should be tolerant."

Many nurses commented on the tiring and stressful nature of the job. Irritations were openly expressed with certain residents who were considered to be too demanding, or those whom it was estimated could do more for themselves:

> "There's a lot of stress on you, ringing for little things all the time. They could do a lot more for themselves, but they won't do more if they've got it into their heads."

In the training session at Nursing home D, a number of nurses shared some of their difficult early experiences of working at the home. The lack of preparation for dealing with dying residents and coping with death was evident in the description of one assistant who could no longer face going into the room where her favourite resident had died. Other nurses admitted that they had no idea of the kind of support needed by dying residents and their families and tended to leave it to other staff.

The balance of residents in terms of their levels of dependency was an important factor for many nurses. Too many "heavy patients" made their job more difficult, tiring and therefore less pleasurable. The number of confused residents was also considered to affect the overall quality of care in the view of both matrons and nursing staff. One matron recalled a period the previous year when there was a high proportion of confused residents in her home and the other residents started to object. She therefore strived to maintain a balance of such residents, commenting that staffing the home would also become a problem if the percentage of confused residents were to increase.

A concern raised by staff in the training sessions at nursing home D, related to being excluded from handover reports or meetings concerning the residents. They asserted that any details about the residents and their treatment had to be picked up in an ad hoc fashion. Communication between the registered nurses and the nursing assistants was considered to be poor. Clearly, the exclusion of a section of staff from

information giving did not promote an holistic nursing approach to care.

When asked if attendance at a training course would improve the nursing care offered by assistants, all those interviewed believed that it would. At nursing home D, those attending the training programme thought that it should be compulsory to achieve consistency in standards. Training was viewed favourably by all the matrons, but there appeared to be many barriers to its introduction. Cost was always a factor, whether it involved releasing staff for a study day at the local hospital, or paying for someone to come in and run a programme. The matron at nursing home B had not considered it before, but given her recent experiences with staff turnover and injury to patients, she resolved to follow up the options.

Most of the matrons were concerned about the poor reputation surrounding the nursing home industry, and asserted that this misrepresented the standards and quality of care offered in their homes. One matron described her frustration with the local residents who were always quick to call

the police and complain should a confused resident wander out of the home, instead of asking that person in to wait, or giving them a cup of tea. She considered that much of the negativity surrounding nursing homes was borne out of fear and ignorance on the part of the public.

Regime

Despite the matrons' claims that residents were treated as individuals and their needs considered, the approach to nursing practice employed in all the homes was very much a task-oriented one. Care was organised around daily events such as getting up, mealtimes, coffee times, bathtimes and retiring times. The mornings were generally observed to be hectic in all the homes, with staff rushing to get through the designated tasks. In contrast, the afternoons were quiet and some staff indicated that they were often bored at this time because there was nothing left to do. Sorting out the linen was a common pastime, but more often staff were to be found congregated in a confused resident's room where they could chat together unobserved.

The ideal regime described by a number of matrons and senior nurses was one where residents could have their own possessions around them and still continue to experience some choice and flexibility in their lives, even though they were now situated in a nursing home:

> "Most importantly this is their home and all the little bits and pieces that they do at home, they should be allowed to do here. If they want to get up at midday, they should be allowed to. Obviously meals have to be standard. I think they should be allowed to potter around ...the average woman spends a lot of her life in the kitchen. It's sad that they can't carry out things like that. If I give Mrs Simpson a duster, it keeps her happy - it doesn't make the place look any better."

The reality of this view was that in all the homes the 'preferred' choice of residents was to do nothing, their day being dominated by the home's routine. The apathy generated in these institutions meant that little interest was expressed by residents for the occasional outing organised. Staff therefore stopped organising outings and events, anticipating that the residents' response would not be favourable anyway.

Although the matrons acknowledged the problem of imposing unfamiliar standards on residents and

recognised the need for individuality, certain standards were seen to be necessary for the harmony of the institutional environment:

> "What right have we got to force residents to bath if they don't want to - as long as they don't start to smell and offend other residents that's alright."

Whilst there was a policy of open visiting in all of the homes, visitors were sometimes seen as potential sources of disruption to the smooth running of daily life, as one nursing assistant commented:

> "Visitors are important, but sometimes they can upset the patients. It would be better if they would come in just once or twice a week."

Ensuring privacy, dignity and the rights of residents were infrequently mentioned by staff, however, such aspects of care were highly valued by one matron. The emphasis at her home was privacy and respect for the individual. This matron was also concerned that residents were able to exercise self-determination, but indicated that she sometimes found it a dilemma to allow total freedom when risk-taking was involved and standards could be affected.

Summary of staff views

The comments made by staff provide another perspective of the concept of quality of care. A number of major issues stand out from the interviews and observations of practice reported on here.

First, was the emphasis placed by the nursing assistants on the physical aspects of care and the task-oriented approach adopted in its delivery. Although matrons and senior nurses placed importance on the psycho-social needs of residents, nursing assistants revealed little awareness of such aspects of care. This is of considerable concern given that it is the nursing assistants who spend most time with the residents and can therefore have a major influence the care and lives of residents. This finding also demonstrates an important difference between the resident's and provider's view of the meaning of quality of care.

Second, the low levels of qualified nursing support, low pay and poor conditions of work, lack of career opportunities, high turnover of

staff, absence of training and low status of nursing home work, were all factors identified by nursing assistants and constituted major sources of dissatisfaction. Under these circumstances, the achievement of a setting that encourages humane and compassionate care is a major challenge. Kane and Kane note that research in this area remains extraordinarily underdeveloped (Kane and Kane, 1987:264). This study begins to shed some light on the difficulties facing nursing home staff and the barriers to improving the quality of care and life for residents.

QUALITY FROM THE REGULATORS' PERSPECTIVE

Standards of care

Since the N.A.H.A. guidelines were published in 1985, the study D.H.A. had used these as standards by which to regulate its nursing homes. At the time of the study, the D.H.A. were in the process of developing their own guidelines based on those of the N.A.H.A. It was the health authority's view that nursing homes should demonstrate progress and commitment towards attaining certain standards and a guide to

achievable standards for the elderly residents of nursing homes in the health authority was produced in 1988. These standards are essentially the same as those of the N.A.H.A., but provide greater detail in some areas, whilst being extraordinarily vague in others. The standards cover four main areas: the physical environment, personal services, nutritional service, and nursing services.

Specification of standards for the physical environment relate to the structure of the buildings, the living conditions and equipment provided. In this section reference is made to providing a homely environment by obtaining items such as pictures, plants, large clocks and fish tanks. However, no mention is made of encouraging residents to bring in their own possessions, or indeed that there should be space to store personal belongings. The specification that all residents should have adjustable beds and chairs of particular dimensions contrasts with the N.A.H.A. guideline recommending that beds may be of a hospital or domestic type, the main criteria being comfort, height and the degree of nursing

care required in the case of a bedridden resident.

The standards for personal services cover social activities, personal grooming, religious and cultural beliefs and language. The provision of social activities, interests and outings are standards judged to prevent institutionalisation of elderly patients. Life review, reminiscence programmes and staff/patient communication that takes into account the biographical details of residents, are not mentioned as being important means of maintaining the individual's self-esteem. Patient choice and preference is mentioned in relation to clothing.

Standards for nutritional service address the nutritional requirements of the elderly in some detail and cover therapeutic diets, choice and presentation of food, mealtimes as a social activity and the provision of alcohol and special drinks. Whilst choice is a requirement for the eating of meals and the food on offer, choice of mealtimes is a topic not dealt with.

Finally, the specification of standards for nursing services covers the objectives of nurses caring for the elderly, individualised nursing care plans, incontinence, the prevention of pressure sores, freedom of movement, personal hygiene, infection control and eliciting the view of patients and relatives. This section declares:

> "The elderly patients within this Health District are entitled to expert and skilled care by nurses who understand and fulfil the special needs of the elderly."

To achieve this standard homes would need to demonstrate that they were providing some form of training for their unqualified staff, or recruiting staff with the necessary experience in the care of the elderly. As the majority of nursing home care is provided by young, unqualified, and inexperienced nursing assistants who to date receive no form of training, then clearly further consideration by the health authority of this issue would be necessary to define at what point staff could be judged "expert and skilled". Interest was expressed by the health authority officers interviewed in the provision of training, but there were no signs of impending action in this area, or that the health authority would consider making some form of

training/education for nursing assistants a requirement of registration.

The care that nurses are likely to be involved in is divided into phases: acute, rehabilitative, continuing and terminal. The nursing objectives relating to the phases include recovery of health, maximising of potential and quality of life, and peaceful death. Whilst this document does not detail how such outcomes are to be achieved, a separate document lists nine areas that should be considered when assessing quality of life (see Appendix 6).

This section further states that "every effort will be made to maintain dignity and privacy", however, no guidelines are provided as to how such concepts can be achieved. This would seem to be important, as staff often mentioned privacy and dignity, but were unable to expand on their meaning. Residents' rights are not mentioned specifically, although the health authority had recently started a complaints procedure.

The only standards that can be considered examples of outcome measures are the details on

prevention of pressure sores and eliciting the patients views. However, the 'structured interviews' suggested will not necessarily be the best method of providing valid and reliable measures of how consumers feel about their care.

Inspections

Observation of an informal inspection carried out at a 29 bed nursing home registered in the study D.H.A. gave some further insight into the priorities and dimensions of quality from the regulator's perspective. The process of inspection involved:

1. A tour of the home with the matron, including bedrooms and bathrooms, but not the kitchens. Access to every room was made after a cursory knock;
2. A brief exchange of words with the residents, generally without an explanation being offered as to the reason for the visit;
3. A short examination of the admission records;
4. Specific questions of the matron about progress towards implementing the nursing process, the induction system in operation for new staff, and staffing levels. A

question was also asked about whether a particular patient was still being restrained (locked in his room).

After the visit, the officer involved commented that he paid particular attention to how the residents were dressed and whether they had "sleepies" in their eyes. He also commented on the situation of the restrained patient and acknowledged that it was not ideal, but sympathised with the home that it was too much of a risk to allow the resident freedom, since on a previous occasion he had taken the matron's car and smashed it up. Despite his expressed concern, the officer did not request to see this resident.

Apart from the need for some decorative attention, the officer concluded that he had no concerns about this particular home and that care was generally of a high standard. The visit lasted for approximately one hour.

Formal inspections were said to last up to three hours and were always unnanounced. On these occasions the residents and staff were interviewed in private; fire regulations and

training checked; and all records scrutinised. Both of the officers interviewed believed that their role was supportive and that when their reports were unfavourable, the proprietors were always invited to discuss any problems.

Overall, the inspection appeared to take on a 'checklist' approach, where the inspection officer concentrated on the tangible and observable aspects of nursing home life. The nursing home matrons were critical of the regulatory process because of this approach. Record keeping and the provision of certain facilities, such as fire precautions or a nurse alarm system, were easy points to check. However, the fulfilment of these requirements would not necessarily indicate whether a resident was happy or satisfied with the quality of care. The provision of a nurse call system, for example, did not guarantee that it would be answered - it was a common complaint of residents that they frequently had to wait long periods before their bells were responded to. Whilst fire safety was a major concern of the health authority, during the whole period of interviewing with residents, fire

precautions were mentioned as being important by only one resident.

There were also signs that the two officers involved in the monitoring of nursing home standards in the D.H.A. were looking for different things. One officer was concerned about the homeliness of facilities inspected, believing that they should not be too clinical and that the nurses should be dressed appropriately and not in "frills". Whereas, the other officer appeared to feel more comfortable with standards of nursing dress and behaviour suited to a hospital environment. The differing approaches adopted by the inspectors were perhaps a result of their backgrounds having been either in clinical or community nursing. Whatever the reasons, this issue highlight the difficulties involved in the achievement of consistency in the interpretation of guidelines and monitoring of standards.

Enforcement of standards

A strong criticism from the officers involved in the registration and inspection of nursing homes was that they had no real power to enforce

standards. During the course of the research, two of the nursing homes seriously contravened the standards required by the N.A.H.A. guidelines and the D.H.A.

Nursing home B contravened the N.A.H.A. Guidelines in three major and very observable ways. First, no lift was provided in a five storey building; second, there was no communal area, lounge or dining room; third, a basement room well below regulation size was in use. Other problems detected in this home during the course of the study posed serious questions about the quality of care being offered. For example, the turnover of staff was unusually high and replacements were proving difficult to find, particularly qualified nurses, with the consequence that the owner was working every day, in addition to being on call for most of the time. A seemingly direct result of the poor working conditions and staffing shortage was the dropping of a male patient when he was being lifted into the bath.

The D.H.A. had not, however, sought at any stage to refuse renewal of registration. The case of

nursing home B was discussed at length with the officers responsible for the registration and inspection of nursing homes. It was ackowledged that this home did not conform to the required standards. That the home was allowed to continue its operation was justified on the grounds that it was well established with a good reputation and a dedicated owner. The officer responsible for this home admitted that it had always been a worry to her. She commented that the present owner had little foresight and that the home could never be sold as a going concern or re-registered under new owners in its current state. The officer's reluctance to seriously pursue the matter appeared to stem from a fear of uncovering a scandal. One alternative posed by the officer concerned was that she would pursue with the owner, the possibility of rearranging the accommodation to conform with the D.H.A. requirements.

In the process of registration and inspection, good, bad and mediocre reputations were inevitably attached to nursing homes by the health authority. Any changes in standards at a particular facility could go unnoticed because of

the infrequent inspections (usually twice annually). For example, since the appeal tribunal ruling and renewal of registration, nursing home B was described as providing good care by the person responsible for its inspection. During the course of the study, however, eight examples of care that directly contravened the requirements of the N.A.H.A. guidelines and the D.H.A. were found:

1. Inadequate staffing levels.
2. Use of restraints e.g. sedatives, geriatric chairs.
3. Unkempt residents e.g. not shaved, washed, dirty creased clothing.
4. Dirty floors and strong smell of urine.
5. Lack of laundry facilities.
6. Food served cold.
7. No provision of wheelchairs.
8. Total absence of any stimulation for residents, e.g. conversation, social outings reading materials, etc.

There were no signs at all that this home was committed to the improvement of standards since the appeals tribunal.

Summary of regulators' perspective

There was evidence that the D.H.A. had started to consider the wider dimensions of quality of care and this was reflected in their recently prepared guidelines. However, the utilisation of an outcome approach in the enforcement of standards was very limited at the time of the study.

Interviews and observations in nursing homes identified that there were serious problems with the enforcement of the most fundamental standards in two homes. Differing approaches to inspection within the D.H.A., a strong hospital orientation, perceived lack of power and time constraints, were just some of the factors inhibiting more effective progress towards putting some of the rhetoric about quality of care into practice.

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CHAPTER 11

IMPLICATIONS FOR POLICY AND PRACTICE

Expanding the concept of quality

This study raises a number of questions about how the quality of nursing home care is defined in current legislation and guidelines and also how it is implementated by the regulatory authorities. It highlights the differences in the concept of quality between consumers, providers and regulators. One of the key difficulties is that the views of the regulators and providers have predominated in setting the standards for the industry, and as a consequence the interpretation of quality of care and quality of life issues has been limited.

Those aspects of care that contribute significantly to the quality of life experienced by residents were identified in this study. Whilst consumers attached importance to many of the elements of care that form a part of the existing regulatory requirements, they also valued highly other dimensions not considered in the legislation

and guidelines which aim to promote the quality of nursing home care.

The limitations of this study have been pointed out in chapter 5. The general application of the findings to the wider population of nursing home residents is not a claim that this study can make. This does not mean, however, that the findings are limited for the purposes of policy. Penetrating the realities of nursing home life by a qualitative analysis of the residents' experiences, has deepened the theoretical understanding of quality and how it might be more effectively operationalised. Analysis of the study's emerging themes and concepts, leads to the identification of a number of areas that need to be considered in the development of standards and enforcement of regulation for the nursing home industry.

Limitations of existing regulations

A major limitation with the regulations is that they do not adequately assess the quality of care being delivered, but rather, focus on the home's

structural capacity to provide care. They rely heavily on physical and environmental standards and offer a checklist approach to measuring these standards.

Furthermore, many of the standards are vague; under the provision of facilities, 'adequate' is the only measure offered for inspectors - to be interpreted as 'sufficient and suitable.' In the N.A.H.A. supplement four pages of guidelines are devoted to the assessment of quality of care and quality of life for the elderly long-stay patient (N.A.H.A., 1988). Sections include guidance on the patient relationship, which suggest behaviour and practice that maximise dignity and independence. Some advice is offered on pre-admission practices, and there is a section on the relationship between staff and patient, which asks a series of questions for use by inspecting officers in assessing whether dignity, social, spiritual and physical needs are met and recreational and diversional activities are provided.

Some crucial issues are addressed by the new guidelines, but they clearly do not yet go far

enough. Important questions such as the provision of information, conduct of staff, resident rights, and personal fulfilment are only touched upon. For example, answers to the question 'How are staff and which staff are trained to show respect to patients?' will not necessarily confirm that respectful behaviour towards residents actually occurs. Professional judgement of quality will therefore continue to be an inconsistent one. More objectivity and reliability needs to be introduced into the regulatory system. There is particular difficulty associated with assessing quality of care for residents with differing needs and the interpretation of the findings of inspection.

It is the ongoing nature of quality that creates problems in setting and measuring standards - the outcome is not stationary and it is the continuing process that has to be regulated. A major re-orientation of the regulations is therefore necessary, so that evidence of the continual achievement of quality care and the quality of life for residents is provided.

The perspectives of nursing home residents in this study provide a good basis on which to build standards and refine regulations.

The advantages of outcome standards

The experiences of other countries offer many lessons for Britain as it strives to improve standards in the nursing home industry. Exploration of recent developments in regulatory criteria in Australia and the United States provides some potential solutions to the regulatory difficulties experienced to date in Britain. The nursing home scene in the three countries has much in common and greater progress could be made in Britain if the most successful elements developed in other systems could be appropriately incorporated.

Defining standards in terms of outcomes expected from care has received a great deal of attention in the United States and Australia. It is in this area that the British regulatory system demonstrates its greatest weakness, although the beginning of this approach can already be seen in

the recent additions to the N.A.H.A. guidelines. This study concentrated on one major aspect of resident outcome - the residents' evaluation of nursing home care. The findings demonstrate that much more attention needs to be focused in the regulatory criteria on the care provided and its effects on the quality of residents' lives. Recommendations of this nature were being made some years ago in the U.S.A. by such authors as Chow (1980) and Ruchlin (1977). Despite measurement difficulties, certain key aspects of quality of life can be specified as regulatory standards.

Outcome standards have recently been introduced for Australian nursing homes with the intention of assisting in setting direction and priorities for the planning of services and practices within homes (Commonwealth of Australia, 1987). Seven major objectives for nursing homes have been identified: health care, social independence, freedom of choice, homelike environment, privacy and dignity, variety of activities and safety. Within the seven objectives are 31 standards each relating to a specific resident outcome. Where

there are difficulties ensuring these outcomes for people with a moderate to severe degree of impairment of intellectual functioning, then it is expected that the resident's representative will be consulted for information and advice.

The structural and process emphasis in the United States regulatory system has been strongly criticised and recent proposals recommend that regulatory mechanisms incorporate outcome measures (Insititute of Medicine, 1986). It is recommended that quality of care conditions should identify desirable resident outcomes of care processes in functional status, physical well-being, social involvement and participation, cognitive functioning, and resident satisfaction.

If adopted in Britain, outcome standards could become a goal for homes to work towards and achieve within a specified time period. During this time the regulatory authority could monitor the progress of homes closely, offering advice to those demonstrating difficulty with the attainment of required standards. The appointment of liaison officers attached to homes has already been

suggested (Challis and Bartlett, 1987:161) and could assist with this task.

There are a number of other options to be considered that would facilitate the achievement of satisfactory outcomes. Strategies to ensure quality of care on a continuing basis could include increasing the visibility of nursing homes, such as the promotion of consumer involvement, and the regulation of training.

Education and training of nursing home staff.

Skills in the dynamics of interpersonal relationships and practical competencies were crucial elements of nursing care identified by residents. Positive motivation and attitudes on the part of staff are essential for high quality care. The most important staff characteristic as determiner of attitudes is the educational preparation of the nurse (Wright, 1988). Nursing staff need the appropriate skills and knowledge to act in a professional manner towards the residents and hence deliver the appropriate level and quality of care.

However, nurses with the appropriate educational preparation are not the chief care-givers in nursing homes. In a study of nursing homes in the South of England only 31 percent of nurses were Registered General Nurses (R.G.N.s) and had undertaken a three year generalist education (Challis and Bartlett, 1987). The two year Enrolled Nurse qualification was possessed by 10 percent of the sample and the remaining 59 percent were nursing assistants, also called auxiliaries, who had no formal nurse education or training. Whilst nursing assistants have become a stable and experienced workforce for routine patient care, in the majority of cases they are recruited literally off the street and learn `on the job.'

With the exception of one home that had established a training programme for the first time, the view, in this study, of nursing home management was that staff education and development represented more of a luxury than a necessity. Other studies have also found that training and education was rarely offered and generally limited to the occasional seminar at the local hospital on topics such as incontinence

(Challis and Bartlett, 1987). Sometimes training relating to fire precautions or instruction on lifting techniques was offered. The Registered Nursing Homes Association have a training manual for nursing auxiliaries, although its use was not all that extensive. Proprietors commented that they did not have the capacity to release staff on a regular basis and also did not consider that they had the skills to offer a training programme themselves.

This study seriously questions the adequacy of present educational preparation of nursing home personnel for the job requirements. The identification of similar problems in the U.S.A. led the American Nurses' Association (1987) and the Institute of Medicine (1986) to advocate the establishment of national standards for minimal educational preparation for nursing aides. Under the Omnibus Budget Reconciliation Act, 1987, nursing aides are now required to receive 75 hours of education. Each state is presently preparing for the local implementation of this education (Wright, 1988).

Whilst authors such as Booth (1987) have argued that education and training of staff in residential homes would ultimately have little effect, because it is the burden of care and pressure on staff that prevent them from maintaining good practice, this study revealed such deficits in basic caring skills that it would be hard to see how the introduction of the most rudimentary form of education of untrained staff particularly, would fail to contribute to an improvement of standards. Of course, it is acknowledged that achieving standards such as privacy, is influenced to some degree by the practical arrangements in homes.

In relation to residential care homes, the Wagner Report recommended that "every establishment should be required to draw up a staff training programme and this should be subject to inspection procedures." (National Institute for Social Work, 1988: 91). A number of training needs were identified by the report: 1. induction training; 2. core training; 3. team development; 4. regular appraisal of training needs.

If there is to be any hope of nursing homes achieving the outcome standards discussed, then recognised and approved pre-service education for nursing assistants will also become crucial and should become a requirement of the regulations. Such a requirement would have the additional benefit of screening out any unsuitable nursing assistants prior to their being given resident care responsibilities.

A suitable educational establishment would need to be identified for the location of new courses. One option would be to establish courses in Further Education Colleges, where appropriate educators and basic `caring' courses are already offered. Such educational institutions could make a major contribution to the development of excellent performance and well-motivated and qualified professionals. The costs involved would necessarily fall to the nursing home proprietors so that potential staff would not have to bear the financial burden. Initially however, some government funding may be necessary to establish educational programmes and subsidise the costs to participants.

Studies are necessary to identify the most effective and appropriate training programme for nursing home staff. A consistent educational model is required for nursing assistants' training, that recognises the essential relationship between perceived training needs and on-the-job experience.

Training may decrease the attrition rate and increase the satisfaction of assistants who in this study complained of lack of respect from residents and management, lack of autonomy and low pay. The greatest benefits should ultimately be seen in the standard of resident care and resident satisfation with care-givers.

Continuing education for Registered Nurses should also be encouraged, since few schools of nursing emphasise gerontological nursing or place their students in nursing homes for experience. Higher education institutions may have a role to play here in offering courses that include content on occupational therapy, dementia in the elderly, sensory deprivation, communication skills, death and dying. Sensitivity training of all nursing

staff during which they are required to adopt the role of resident for at least a day has also been found to be a most beneficial training aid (Moss and Halamandaris, 1977:209).

One strategy for raising the status of gerontological nursing in the curriculum would be for nursing homes to establish collaborative relationships with schools of nursing. Such arrangements could be mutually beneficial and there have been some successful experiments in the United States (Huey, 1985; Burke, 1987).

Information, admission and assessment

The research highlighted the need to prepare residents more thoroughly and support them in their transition to care.

Stein et al (1985) suggest that a preadmission or admission screening of new residents could help pinpoint specific problem areas. Staff can then be allerted to explore that area further in order to understand the reasons for the resident's concerns. They argue that a state of anxiety about

placement can lead to dissatisfaction across all areas of care and create distance between resident and staff.

The provision of appropriate information to potential and new residents would arguably alleviate some of the anxieties of placement. Residents' descriptions revealed the importance of this. Challis and Bartlett have argued that the provision of information should receive greater attention and recommend the following (Challis and Bartlett, 1987:148):

- The preparation by N.A.H.A. of materials on the issues involved in deciding to enter nursing home care.
- Guidance from D.H.A.s on alternatives to nursing home care, availability of community services and other forms of help.
- A brochure prepared by nursing homes including details as specified by the D.H.A.

The provision of such a package of care would involve relatively little cost to homes or authorities. In relation to the brochure, the provision of such information could be a

prerequisite or requisite of registration or re-registration.

The current regulations do not require a standardised assessment of any kind. A form of on-going assessment would seem to be the only way to alleviate some of the concerns informants expressed about admission and also their criticisms about the inadequacy of the care they received, e.g. lack of rehabilitation, emotional support and self-fulfilment.

Through assessment, the physical, medical and psychosocial functioning of residents can be assessed and care planning improved. Therapy programmes that encourage personal fulfillment for the individual resident, as opposed to activities focused exclusively on the group would be more in keeping with the residents' preferences.

The findings from this study suggest that information on physical and mental function, health risk factors, diagnosis, prognosis, short and long-term goals as well as social history items, is essential for quality of care purposes.

Also, periodic reassessment is essential to check the resident's status changes and modify the care plan if necessary. Such assessments would provide valuable quality of care indicators available for the authorities to audit.

The introduction of ongoing assessment of residents would not be without its difficulties. An important facet of such assessment would be the introduction of the `nursing process' for which a major educational programme would be necessary to convince nurses in the industry that it was warranted. Staff in this study indicated that the main aims of nursing home care were to make the residents comfortable, provide a homely environment and basic care needs. Much as Booth found in his study of residential homes, encouragement of independence and any programme of rehabilitation were not considered to be the objectives of the homes studied (Booth, 1987). Increasing the percentage of Registered Nurses in nursing homes would make the phasing in of the nursing process an easier task.

The introduction of assessment would have staffing implications too. Since most of the care in nursing homes is provided by nursing assistants who have had little or no training, and who tend, on the average, not to remain in the same job for very long, it would be essential that a sufficient number of Registered Nurses were available to supervise the residents' assessments, health care and treatment.

The form of assessment with potentially the greatest impact on the nursing home industry is needs assessment. In response to the recommendations of the Griffiths Report (1988), the Government recently gave local authorities the key role in running community care. By 1991, new entrants to private residential and nursing homes will have to have their need for such care assessed before social security agree to meet the costs.

It has been long argued that the introduction of needs assessment would reduce premature or inappropriate placements. There is also the view however, that for assessment to have any merits,

it must consider wider issues than level of dependency and ability to pay (Power et al, 1983). Suitability for residential living, life experiences and personality are influences that bear on the successful fit of an individual and their environment. It is important that such an approach is incorporated into the assessment system which is finally established for the private residential and nursing home sector. Only then will some of the concerns raised by residents in this study be addressed.

In Australia, an assessment system for potential nursing home residents has recently been introduced and is coordinated by multidisciplinary geriatric assessment teams. The functioning of these teams varies considerably across the States and Territories and their effectiveness has yet to be evaluated. In Britain, for the proposed assessment system to be a success, a collaborative approach between local authorities and health authorities will be necessary.

Consumer participation

The findings of this study strengthen the argument for taking the consumers' views and preferences into account in practice and policy formulation for the private nursing home sector. Such a view is no longer new and has been advocated in a number of recent reports (National Institute for Social Work, 1988; Griffiths, 1988). Less attention has been paid however, to developing strategies that incorporate the consumers' view in policy and practice.

Systematic arrangements should be made to determine the value preferences of the residents or those most concerned about their well-being. It is a fundamental psychological need for adults to exercise some personal choice on matters involving the quality of their daily lives. Also, staff need to obtain systematic feedback on the care needs and desires of individual residents to ensure that their plans for care fit the residents' perceptions of their physical and psychosocial needs.

The current regulatory system is somewhat limited in monitoring the process of care to ensure that residents opinions/rights are protected. Inspections take place just twice a year in ordinary circumstances and there is no effective process of monitoring resident/staff interactions in between statutory inspections. Furthermore, the problems of staff turnover, lack of training and heavy workloads mean that staff/resident interactions are often unsatisfactory and leave dependent residents open to abuse, neglect and violation of rights. Physical, mental and financial infirmities make many residents incapable of assertion and self-protection and they are therefore, ineffective in influencing the behaviour and attitudes of nursing home staff.

Consumer advocacy

There was strong evidence from this study that the introduction of a form of consumer protection in nursing homes would be advantageous. Advocacy schemes are an important mechanism in ensuring that the maintenance of standards such as consumer rights is ongoing. Effective consumer advocacy

schemes help residents communicate complaints to appropriate outside agencies that can help them.

In recognition of the need for stronger consumer protection activities in United States nursing homes, the Ombudsman programmes emerged in the early 1970s and became a statutory requirement in 1978. Although the Ombudsman programmes vary widely in their effectiveness (Institute of Medicine, 1986), their intention is to help individual residents and their families negotiate with nursing homes and regulatory agencies. They deal with problems beyond the scope of regulation. Monk et al (1984) highlight the numerous approaches to the implementation of the Ombudsman programmes in the United States. Two main areas of variation are distinguished; collaborative *versus* contest, and broker *versus* therapist. The analysis reveals that staff were not always convinced of the essential nature of programmes and their objectives and that the programme had low visibility amongst residents. Such findings are important when considering the potential of Ombudsman programmes in Britain.

Two specific advocacy models have recently been proposed in Australia (Australian Department of Community Services and Health, 1989). The first is the community visitors' scheme, the aim of which is to ensure that all consumers have access to outside information, support and advice when they require it. Appropriately appointed and trained visitors, preferably older non-residents, would regularly visit the home and would be available at other times if required. Such a role could encourage resident involvement and participation; developing means to increase the involvement of family and friends; mediating between the resident and management over a particular issue; and developing links between the resident and the community. This scheme would be particularly helpful to those residents without family and friends and who are isolated from the general community.

A second model recommended to work alongside the first, is a national advice and network agency. This would provide the necessary information, assistance and ongoing resources for the community visitors' scheme. Its role would include the

provision of advice and assistance to residents and their supporters, particularly regarding legal action. It would also have a broader role of recommending policy change and the development of performance indicators to enable ongoing evaluation of nursing home standards.

Whilst the establishment of formal advocacy programmes would be an important mechanism for improving the accountability of nursing homes and protecting residents rights, other means of improving the visibility of nursing homes in the community would be through the introduction of volunteer schemes. Where residents had experienced volunteer visitors, they described the experience as a very positive one.

Enforcement: current practice and future options

The problem remains as to how standards can best be implemented. If standards were to be expanded to incorporate the key dimensions of quality identified in this study, it is doubtful whether the current enforcement mechanisms would be adequate.

There are three sanctions currently available to D.H.A.s if homes fail to comply with the requirements of the 1984 Act, the 1984 regulations and any conditions which the D.H.A. properly determines under the legislation: to cancel registration, refusal to register a home, or to vary the conditions of registration.

Under the 1984 Act, emergency orders can be issued by a Justice of the Peace to cancel or modify conditions of registration; these orders have immediate effect and can be used to close a home. As noted in the supplement to the N.A.H.A. guidelines, it is for the registration authority to decide between a proposal to cancel the registration or to prosecute in the Magistrates' Court (N.A.H.A., 1988). Authorities are advised that cancellation may be regarded as "draconian (unless there is serious risk to patients and urgency)." The rapid and more local and public nature of the Magistrates' Courts are also seen to be advantages of this course of action.

That nursing homes have demonstrated a reluctance to use these available santions does not imply

that all nursing home facilities comply with the standards or requirements. In this study, both residents and regulators identified weaknesses in the existing enforcement system. Breaches of the most fundamental nature were evident in some of the standards observed. For example, there were basic inadequacies in nursing homes' physical environment and deficiencies of this nature clearly had an impact on the quality of residents' lives.

The limited use of sanctions can be explained largely by the enforcement style adopted. In this study, the actions of the D.H.A. more closely resembled the compliance model (see chapter 1). There were a number of intervening factors that could account for the use of this style of enforcement. First, the imposition of such standards as closure could have a detrimental effect on residents, when the intention of sanctions is to improve the quality of care for residents and not reduce it. Second, enforcement procedures are alien to N.H.S. officials and many registration officers may be uncertain about the

exercise of their rights and responsibilities in registration and inspection (Davis, 1987).

The inspection officials thenselves identified a number of factors that inhibited effective enforcement of standards. Perceived lack of power and lack of alternative provision within the D.H.A. should a home be closed, were major influences on how guidelines were interpreted.

In the five years since the present regulatory framework was set in place, there have been developments that make a more effective regulatory system possible. The regulatory system requires a major re-orientation to make it focus on the care being provided to residents and the effects of the care on their well-being. This will clearly involve certain modifications to the existing approach affecting standards, surveillance, enforcement policies and procedures. In particular, the compliance (enforcement) policies and procedures will have to be strengthened whilst ensuring as little negative impact on residents as possible.

The main strategies available to authorities to maximise compliance with standards involve either the use of sanctions or incentives. However, as Parker (1987: 115) points out, in reality, a combination of approaches is necessary and a major challenge is the achievement of a balance between regulation through sanctions or regulation through encouragement and negotiation. He further identifies the potential problems in the implementation of regulation to include the limited resources made available for its implemention and the shifting market developments demanding further new revised mechanisms.

A system of fines operates in New York State, used more as a form of suspended sentence designed to improve behaviour (Day and Klein, 1987). Fines may be imposed by the Magistrates Courts in Britain, but this form of sanction has not been developed or used extensively. In the long-term interests of residents, the imposition of fines may be counter-productive as there would be the possibility that the quality of care and quality of life might be reduced in order for the fine to be paid.

Compliance strategies recently proposed in Australia may have some relevance for Britain (Department of Community Services and Health, 1989). One option is for the publication of inspectors' reports to provide information on the compliance with standards by particular homes. This would act as an incentive by publicising the many homes which meet the required standards and those which have introduced innovative practices. Such a list would also be of assistance to potential residents and their families in the selection of a nursing home. Nursing homes should be given an opportunity to comment on the report before its completion.

A second option proposed is the appointment of an administrator to run particular homes when all other avenues to improve standards have failed. In Britain this person could be an appropriately qualified officer appointed by the D.H.A. The D.H.A. could then specify the results and changes to be achieved within a certain period of time.

The introduction of more stringent enforcement would require greater prescription in the

legislation and regulations as to the specific standards to be met. Consequently the discretionary powers currently exercised by D.H.A.s in negotiating with homes as to what is `reasonable' quality, would be reduced. It would also mean that there would be less flexibility to take other factors into consideration, such as inadequate forms of alternative provision. This would currently impinge on a decision to close a `borderline' establishment.

A further implication would be to reduce the developmental role taken on by many D.H.A.s, where the emphasis is advisory and improvements are encouraged over a period of time. Stronger sanctions would also increase the cost of policing.

There remains the question of who is best equiped to enforce nursing home standards. Some of the conflicts experienced by the D.H.A. in the effective regulation of homes could be overcome by the creation of an independent inspectorate of homes, with powers to enforce the standards required by the regulations. The National Consumer

Council recently recommended that the Government should create an independent inspectorate for all local authority, private sector and voluntary homes, with full investigatory powers (N.C.C., 1989). In relation to nursing homes, one possible option would be a national independent inspectorate with a team based in each region to monitor standards and enforce regulations. The functions of registration could be left with the D.H.A.s. Possible drawbacks to such an arrangement include the resource implications of setting up such a large body, and potential coordination problems.

Yet another option would be to decrease regulation and allow market forces to work. Critics of state regulation such as Friedman (1962) have argued that a free market and normal consumer demands for goods and services of a satisfactory standard would be sufficient mechanisms of regulation. In contrasting regulation to the functioning of an ideal market, Vladeck describes it as "cumbersome, time consuming and inefficient;" but with a number of virtues including due process, stability and accountability (Vladeck, 1981). Bishop argues

that, if capitalized upon, a competitive nursing home market could address problems of over-consumption, excess costs, poor quality and barrriers to utilisation (Bishop, 1988). Poor information on the quality of care is however likely to be a continuing problem.

Although many providers would welcome a reduction in what they view as government interference in the operation of their homes, it is unlikely that market forces will be allowed to take over in the case of nursing home regulation for two main reasons. First, is the current degree of state financing involved through the supplementary benefit system. Uncontrolled growth of nursing home beds would create further escalation in supplementary benefit funding and there would be a danger that additional beds would quickly be filled with residents now being cared for privately and informally in the community. As the market essentially consists of two sets of clients: those paying privately and those supported by the state, it seems that regulation is one form of protection for the more vulnerable consumers.

Second, given the history of nursing homes, it seems unlikely that market forces will have a positive effect on the quality of nursing home care. In the U.S.A. and Britain, it was precisely the scandals and abuses revealed in the nursing home sector that provided a major impetus in the development of regulation in the first place. Protection of rights is something not best served by market forces.

Challenges for the future

Day and Klein (1987) argue that to be more effective, a regulatory system should address the whole situation, including the social environment:

> "An effective system - that is, one which protects the individual patient as well as bringing the nursing home into line - must combine techniques and social interaction, relations with the community and the ecology of the nursing home industry."

Of course this model is time-intensive as it will require officials to spend time talking informally with residents and staff, as well as assessing physical standards.

An expanded level of knowledge about the concept of quality should not imply that the number of

nursing home regulations be multiplied to cover every dimension of quality that emerged from this study. Rather, energies should be redirected to the elements identified as priorities. As these directly relate to outcomes of resident care, then time will not be taken away from the resident whilst attending to regulatory requirements. Furthermore, residents' expressions of satisfaction could become the signal for further investigation.

The introduction of a regulatory system that focuses on resident outcomes is insufficient in itself. Improvements in quality can only be achieved if an appropriate framework is established to promote the kind of care that residents want. Measures will need to be employed that facilitate the convergence of the differing concepts of quality held by residents, providers and regulators. Education of providers and consumer advocacy/participation are two important elements of a necessary framework. Education will increase the professionalism in nursing homes and therefore improve the self-esteem and morale of nurses at all levels. Ongoing resident

participation will enable the consumers' views to be represented and provide an opportunity for them to be integrated into policy and practice.

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APPENDICES

APPENDIX 1

Acts and Statutory Instruments Affecting Nursing Homes for Elderly People

Registered Homes Act 1984
Nursing Homes Regulations 1984, SI 1984/1578
Health Services Act 1976 (Part III) - as amended by 1980 Act
Health Services Act 1980
Health Services (Authorisation) Regulations, SI 1980/1241
Mental Health Act
Health Circular, March 1986, HC(86)5, 2HC(81)8
National Health Service Act 1977

Medicines Act 1968
Misuse of Drugs Act 1971
Misuse of Drugs Regulations, SI1973/797
Misuse of Drugs (Safe Custody) Regulations, SI1973/798

Cremation Act 1902
Cremation Regulations, SI 1952/1956, 1965/1146

Nurses, Midwives and Health Visitors Act 1979
Nurses, Midwives and Health Visitors (Parts of Register) SI 1983/667

Health Services and Public Health Act 1968
Food Hygiene (General) Regulations, SI 1970/1172
Fire Precautions Act 1971
Health and Safety at Work, Etc., Act 1974
Town and Country Planning Act 1971
Employment Protection (Consolidation) Act 1978
Tribunals & Inquiries Act 1971 Section 13 (1) - amended by 1984 Act

APPENDIX 2

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14.3.88

Dear Resident,

SURVEY OF RESIDENTS IN PRIVATE NURSING HOMES

I am conducting a study of residents in private nursing homes and will soon be visiting your home for a few days. I would like to ask for your assistance with the study and wonder if it would be possible to talk to you during my visit.

I am interested in finding out about your experience of life in a nursing home, how you came to choose this particular home, the aspects of care that are important to you, and how you find living in a nursing home compared to your previous home.

I hope that you will feel able to help, as it is important that the views and experiences of people living in nursing homes are known and can be taken into account by those concerned with making your stay a happy one.

Of course our discussion would be completely confidential and your views would remain anonymous and used only for the purposes of the study.

Thank you in anticipation,

HELEN BARTLETT
Postgraduate student

APPENDIX 3

INTERVIEW GUIDE - RESIDENTS

1. What made you decide to move into a nursing home?
2. Did you know what to expect when you moved into the home? How did you feel when you arrived?
3. Tell me about your typical day in the nursing home?
4. What do you think is most important for residents about living in a nursing home?
5. What would you do if there was something you did not like about the home?
6. What are the best things about living in a nursing home?
7. What are the worst things about living in a nursing home?
8. Are there any changes that could be made to improve life in a nursing home?
9. Do you have any plans for your future care or accommodation?
10. What advice would you give to someone thinking about moving into a nursing home?

APPENDIX 4

INTERVIEW GUIDE - STAFF AND PROPRIETORS/MATRONS

1. Could you say what your motives are for working in a nursing home?

2. What are your chief responsibilities within the home?

3. Do you have any views about the meaning of quality of care in a nursing home?

4. How can quality nursing care be achieved? What are the main factors influencing its achievement?

5. Does the home have a particular philosophy of care? What is it?

6. What are the main priorities in the delivery of nursing home care?

7. (MATRONS ONLY) Do you have any strategies for promoting good nursing practice?

8. Do you have any prior experience/preparation for nursing elderly people?

9. Have you attended any training sessions/in -service education recently?

10. Tell me about your general experiences of working/running a nursing home?

11. What are the major satisfactions and dissatisfactions of working in a nursing home?

APPENDIX 5

INTERVIEW GUIDE - HEALTH AUTHORITY

1. Which guidelines are used for inspection of nursing homes - N.A.H.A. or D.H.A.?

2. Tell me about the inspection procedures - frequency, duration, format, etc.?

3. How are standards enforced in nursing homes by the health authority? Please give some specific examples?

4. What in your view are the major determinants of quality of nursing home care/life?

5. What are the factors that facilitate or inhibit the achievement of quality of care?

6. Currently, what are the key issues in the registration and inspection of nursing homes in this D.H.A.?

APPENDIX 6

QUALITY ASSESSMENT
(A guide prodided by the study D.H.A.)

1.0 Quality of Life

Because mental handicap, mental illness and geriatric patients are often long-stay; because by the very nature of their illness they are less able than most patients to stand up for their rights and because there are often no relatives to safeguard their rights, it is a prime duty of management to ensure that the quality of life of such patients is safeguarded. In assessing quality of life it is imperative that staff should apply to patients the expectations they would have themselves in the particular circumstances.

1.1 Dignity/Self-determination

Is the patient treated as an automomous individual with rights? Do the patients take decisions for themselves? Is the patient's wishes given due weight?

1.2 Meal/Diet

Do the patients have a 'normal' pattern of meals and at 'normal' times? Do they have a change of menu? Are their particular likes and dislikes attended to? Is the food served in an appetising manner? Is it hot?

1.3 Environment/Surroundings

Is the environment pleasant/ Is it homely? Is it warm/cool?

1.4 Occupational/Recreation

Do patients have access to occupational therapy/recreational therapy? Are outings/holidays privided? What do patients do at weekends/in the evenings?

1.5 Clothing/Possessions

Do patients have their own clothing? Do they choose it? Is it approprite? Is it normal? Do patients have their own personal possessions?

1.6 Visiting

Is visiting by relatives and friends encouraged? Is it unrestricted? In the absence of relatives/friends, do volunteers visit patients? If so do they do so regularly and is it the same volunteer?

1.7 Daily Programme/Regime

Is the daily regime flexible and non-institutional? At what time are patients woken up? At what time do patients have to be in bed? How long do the patients spend out of bed? Does the regime vary from day to day? Is it different at the weekends? What control do patients have over the regime?

1.8 Privacy

Do patients have any privacy? Can they wash, go to the toilet in conditions of reasonable privacy?

1.9 Special Service

Do patients have spectacles? Are they worn? Do they have hearing aids? Do they work properly? Are they worn? Do they have dentures? Are they named? Are they worn by the owner? Are patients' needs for spectacles, hearing aids, and dentures regularly reviewed?

1.10 Spiritual Comfort

Are patients visited by the chaplain/spiritual adviser of their choice? Are the particular needs of immigrants catered for? Are the religions of all patients known?

APPENDIX 7

OVERVIEW OF DATA ANALYSIS

Categories	included subcategories
ADMISSION TO CARE	- admission arrangements - circumstances of admission - factors affecting choice - first impressions - preparation for admission
CARE GIVEN BY NURSING STAFF	- management of care - technical care - art of care - continuity of care - availability of care
SOCIAL ASPECTS OF CARE	- passing the time - social interaction - communal activities
INSTITUTIONAL CARE	- physical environment - physical amenities - services provided - institutional regime
FINANCIAL ASPECTS OF CARE	- cost of care - administration of finances - financial assets
ADJUSTMENT TO CARE	- settling in - nursing home as place to live - the future

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